

HOPES AND DREAMS: LEARNING  
FROM THE  
PERCEPTIONS  
OF  
“HIGH RISK” PREGNANT  
ABORIGINAL WOMEN.

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Graduate Studies and Research  
In Partial Fulfillment of the Requirements  
For the Degree of Master's of Science  
In the Department of Community Health and Epidemiology.

University of Saskatchewan

Saskatoon

By

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## ***ABSTRACT***

A qualitative study was conducted to identify perceptions of high-risk pregnant Aboriginal women during pregnancy. Five women were interviewed by the researcher who is also Aboriginal. Each woman was a client of the Healthy Mother Healthy Baby pregnancy outreach program in Saskatoon, and was considered to be at high-risk for poor pregnancy outcomes. Interviews were conducted utilizing a phenomenologically-based model of research, from which emerged themes or commonalities of thought between each woman during this time of their lives. The themes were discussed with Aboriginal women elders who worked with Aboriginal families in Saskatoon, for further insight and discussion of the findings. The themes were collated under one general theme called 'hopes and dreams.' Each theme included the interest of these women to 'want to' move ahead with their lives in the area of improving their relationships with their offspring, their partners, and within themselves. Though each women talked about these areas as being important, all except one did not manifest them in their lives.

The implications for the delivery of health care services include the need for health care workers to gain further understanding of the positive motivational factors of high-risk pregnant Aboriginal women that work towards achieving long-term positive behavioural changes, and thus reduce the risks of poor pregnancy outcomes. Other recommendations from this research for health promotion programs include the development of a partnership with the urban Aboriginal community in delivering culturally-based services and teachings to complement the educative and supportive model of program delivery.

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## ***DEDICATION***

This research is dedicated to Aboriginal families, women and children everywhere. May your hearts continue to grow in love and may your strength be renewed like the eagle.

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## ***LIST OF ABBREVIATIONS***

POP	Pregnancy Outreach Program
HMHB	Healthy Mother Healthy Baby

## CHAPTER 1: INTRODUCTION

### 1.1 Introduction

A friend, with whom I spoke frequently about local community issues in Saskatoon and who had attended community meetings on a professional basis, asked himself during one of the meetings, "*Who* is the 'at risk' population?" As he was telling me about this question, it struck me deeply. For the first time I felt a sense of guilt for being one of those who used the term habitually in my career as a health care provider. The term, 'at risk' or 'high-risk population' seemed for the moment to be a catchall phrase, which is descriptive, referring to individuals believed to have a higher than average probability of poorer health, based on certain predictive factors; however, it says very little about the essence of the population it is referring to. As an Aboriginal nurse, I immediately thought of pregnant Canadian Aboriginal women, whose distressing health profile has been elaborately described in statistics and supporting biomedical research. Though the high-risk profiles of some Aboriginal mothers and children are widely accepted by health professionals, I believe there remain elements surrounding pregnancy of high-risk pregnant urban Aboriginal women that could be further explored.

In this qualitative study, using a phenomenological approach, I attempted to capture some of the deeper meanings and perceptions of pregnancy attached to the experiences of a few high-risk pregnant Aboriginal women who were utilizing the Healthy Mother, Healthy Baby (HMHB) Pregnancy Outreach Program (POP) in Saskatoon. My hope is that we who are health care providers will listen and learn with our hearts and minds. Perhaps this study will provide insights that will help to bridge the chasm between health care providers and Aboriginal clients, resulting in more effective services.

## 1.2 The Problem

For the past few decades, the health of Aboriginal people of Canada has been studied with great concern. As I developed my proposal for this study I wondered, "Where will my research on Aboriginal people fit in? Will it be another study showing our inferior health and widespread social problems?" When I approached an elder for advice, she said, "Make sure that something good will come out of it, for our people". I told her about my concerns surrounding the health of Aboriginal women during pregnancy, and their offspring. She agreed that this is an important issue. According to local traditional teachings, pregnancy is a sacred time in life, when women should be taught healthy behaviour in order to prevent Fetal Alcohol Syndrome, premature births and other physical, emotional, intellectual and spiritual problems in the child. She also stressed the need for healing of the mother and family. "Never mind the high-risk factors, these women need nurturing, love and support, and the teachings of their culture." Several Aboriginal communities and organizations in Canada share these concerns and view it as a priority in their journey towards wellness.<sup>1 2 3 4</sup>

Prenatal outreach programs were developed in an attempt to overcome some of the social, economical and cultural barriers associated with high-risk pregnant women, many of whom are Aboriginal. The challenge with providing prenatal health services to high-risk Aboriginal women, however, is to remain relevant and sensitive to the unique needs of these clients. Though health care providers have a greater objective understanding about the environmental, physical, and socioeconomic risk factors associated with high-risk pregnancies, questions still remain as to how high-risk pregnant Aboriginal women perceive their pregnancies.

The question that I intended to address in light of the current maternal health issues surrounding Aboriginal women in Canada was, what are the perceptions of pregnancy of urban high-risk Aboriginal women during pregnancy?

As will be explained in the methodology chapter (Interview Questions 3.4.2.1), the question that evolved out of the interviewing process was, what are the perceptions of urban high-risk pregnant Aboriginal women during pregnancy?

### **1.3 Purpose of the Study**

The purpose of examining the perceptions of urban high-risk Aboriginal women is to help health care providers listen, learn, and hopefully gain further enlightenment and understanding of their clients' experiences of pregnancy. The audiences for this study are primarily health care providers and others working with this population in Saskatoon. The other purpose for listening is to give these women a voice, not that they have not been listened to in the past, but perhaps they can be heard in a different way. From my personal knowledge of the local community, it seems Aboriginal women are willing to tell their stories, if they feel someone will listen. How the results are received is up to the health care providers. I suspect, however, that the participants and local elders will be interested in the follow-up to this study.

#### **1.3.1 Personal Interests and Assumptions**

Looking ahead and thinking of ways that health can be promoted and diseases prevented in the Aboriginal family is my main area of interest. My antecedents are Aboriginal, coming from the Mushkegowuk Territory of James Bay, Ontario. I would consider myself an urban Aboriginal woman, associating on a professional and personal basis with the Aboriginal community here in Saskatoon. I do not speak my Native language, and I was raised off the reserve after my adoption at five years of age. I am a single parent of four young children. At the beginning of this study I lived in a low-income Native housing unit, in a middle-class neighborhood in Saskatoon. Towards the end of the study I lived in my home community of Moose Factory, Ontario where I worked as Health Director for the Moose Cree First Nation people.

I have felt the effects of poverty as well as the effects of an unhealthy relationship with my children's father, who is also Aboriginal. During my work as a registered nurse, I worked with Aboriginal mothers and their families both in the hospital and in their homes, my favorite area of work being maternal health. In summary, I feel that to a certain degree, I understand what it is like to be an urban high-risk Aboriginal pregnant woman, from a personal and professional perspective. The assumptions I hold as a result of my own experience are explained in more detail under collection of data.

#### **1.4 Definition of Terms**

The conceptual framework of this study is based upon the process of describing and analyzing the perceptions of pregnancy of high-risk Aboriginal pregnant women in Saskatoon, since there is no body of theoretical knowledge that relates to the topic, and because this research uses a phenomenological approach. The terms that will be used are defined as follows:

**To perceive:** According to Webster's dictionary, this means to obtain knowledge through the senses; to observe and understand. <sup>5</sup>

**Perceived world:** The perceived world is viewed as the access to human experience, it is our first awareness of being in the world. When describing lived experience, one is directed to the perceived world. Elaboration of the perceived world (or life experiences) will increase understanding. <sup>6</sup>

**Phenomenon:** This is defined in Webster's Dictionary, as anything appearing or observed: <sup>7</sup>

**High-risk:** A term used to describe a person or group of people believed to have an elevated risk of poorer health, or some particular health problem, because they possess certain characteristics associated with poorer health. In this study it will refer to the guidelines as defined by the HMHB POP in Saskatoon, when scoring their prenatal clients (see Appendix A).

**Aboriginal:** A generic term for native peoples, including First Nations, Métis and Inuit. The term First Nations people describes the original people in Canada. Other terms that are also used to describe First Nations people include: Registered Indians (registered under the Indian Act), Status Indians, or Treaty Indians.

**Urban Aboriginal woman:** A woman of Aboriginal descent who lives in the city for any length of time, even if she moves frequently between the city and her home community.



## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 Introduction**

Review of the literature shows that for the past few decades many quantitative and qualitative studies at federal, provincial, private and institutional levels have been completed in the area of Canadian Aboriginal maternal and child health. I have summarized the research in three main areas; the profiles of high-risk Canadian Aboriginal mothers and their children, the cultural perspectives of Aboriginal women, the perspectives of health care workers, and pregnancy outreach programs in Canada.

### **2.2 High-Risk Aboriginal Children**

National health statistics for Aboriginal infants, such as perinatal, neonatal, and infant mortality rates, as well as post-neonatal and infant morbidity rates, have improved over the years but still remain higher than those of the general population of Canada.<sup>8 9 10</sup> Aboriginal stillborn rates are three times those of the general population, and infant mortality rates are currently comparable to the general population of Canada in the 1960's.<sup>11</sup> Though Aboriginal women do not show a higher incidence of giving birth to low birth weight (LBW) babies at full term, they still contribute significantly to the LBW population due to the increased incidence of prematurity in their offspring.<sup>12 13</sup> LBW and prematurity are considered to be the most important risk factors for infant mortality, including Sudden Infant Death Syndrome (SIDS), and childhood disability of congenital or perinatal origin.<sup>14</sup> The 1990 summary of the Health Status of Canadian Indians and Inuit states that congenital anomalies are the leading cause of death of Indian infants.<sup>15</sup> Though there is a lack of published research in Canada regarding the prevalence of Fetal Alcohol Syndrome (FAS) in the non-Native population to make a valid comparison,<sup>16</sup> it is believed that the prevalence amongst the Aboriginal population is very high.<sup>17</sup>

The long-term economical, social and emotional costs related to a child who is born at a low birth weight or with Fetal Alcohol Syndrome are staggering, and of great concern to health care providers and Aboriginal communities across Canada. The Canadian government has given high priority to finding ways to deal with these highly preventable situations.<sup>18 19</sup>

### **2.3 High-Risk Aboriginal Pregnant Women**

“It sometimes seems as if pregnant women are perceived as little more than containers for the ‘real’ patient—their unborn children.”<sup>20</sup> In the attempt to intervene and prevent the immediate effects on a baby who may fail to thrive in utero, there is a concentrated effort on the part of health practitioners to try to control or reduce the biomedical risk factors within the pregnant woman.

#### **2.3.1 Biomedical Factors**

Aboriginal pregnant women are screened carefully by health care providers, because they frequently have, or are at risk of developing a number of the following obstetrical risk factors, which may result in poor pregnancy outcomes. These include high parity,<sup>21 22</sup> young age during pregnancy,<sup>23 24 25 26</sup> gestational diabetes,<sup>27 28</sup> obesity,<sup>29 30</sup> high blood pressure,<sup>31</sup> smokers during pregnancy,<sup>32 33</sup> urinary tract infections and sexually transmitted diseases,<sup>34</sup> malnourishment,<sup>35</sup> and anemia.<sup>36</sup> There is also concern about the steady rise in HIV infection in the Aboriginal heterosexual population.<sup>37</sup>

Having a medical condition or disease involves a complexity of individualized reactions and perceptions.<sup>38</sup> “The status of the patient’s health is largely dependent upon her perception of her environment and her reaction to it based upon her systems of ethics, beliefs, and values.”<sup>39</sup> Aguilera and Messick, emphasize three areas which can affect how people adjust to a medical crisis in their lives: the client’s perception of the crisis, the client’s coping mechanisms (which could be positive or negative), and the client’s support systems (negative

or positive).<sup>40</sup> If the woman is unable to mobilize her resources to deal with the problem, or if her coping mechanisms fail, she is at risk of succumbing or giving up to the pressures around her.<sup>41</sup> It gets even more complicated if she perceives her problem as unavoidable, uncontrollable or a punishment.

There is little published research that has explored the perceptions of Aboriginal women living with any of the above biomedical conditions. However, one study, conducted by the Aboriginal Nurses Association of Canada (ANAC) in 1993 looking at sexuality of Aboriginal women, offers the reader some of their perspectives such as why some women have unsafe sexual practices:

It has been pointed out that many Aboriginal women lack power and assertiveness in a sexual relationship, and this is especially true for young Aboriginal women. The fear of abandonment and violence precludes the insistence on safer sexual practices between partners and discussions on sexual histories.<sup>42</sup>

One project, which explored the perceptions of diabetes by Native young people in Arizona, showed how perceptions could be diverse and unpredictable. These included the perceptions that diabetes was a disease of the weak or elderly, or that it had something to do with bad blood, or that it was an invisible evil force that people were helpless against. A few of the participants seemed to understand the physiological aspects of diabetes.<sup>43</sup> For some Aboriginal people, particularly those who live in the traditional way, diabetes or any other illness is viewed as a spirit or living entity who should be respected and whose lessons should be listened to.<sup>44</sup>

### **2.3.2 Psychosocial and Behavioural Factors**

Psychosocial and behavioural risk factors of pregnant Aboriginal women largely reflect the effects of living in poverty and the breakdown of the family.

The Community Task Force on Maternal and Child Health in Manitoba in 1981, described the characteristics of mothers in poverty as, "...being of high parity, young, low income, seeking antenatal care late in pregnancy, unemployed, with low educational attainment."<sup>45</sup> Recent statistics indicate that Aboriginal women tend to have children at younger ages than non-Aboriginal women, having the highest fertility rates in Canada.<sup>46</sup> They are also more likely to be single mothers.<sup>47</sup>

Aboriginal women in Canada have the lowest average individual income of any population sub-group, and the lowest levels of education.<sup>48 49</sup> Literacy skills or lack of formal education plays a major role in the ability of Aboriginal women to take control over their lives, and in their ability to achieve a higher standard of health and living.<sup>50 51</sup>

Transiency between the rural or on-reserve community and the urban setting is high. This transience produces certain problems for Aboriginal women such as financial dependence on the government, isolation, loneliness and lack of family support.<sup>52 53</sup>

The saddest statistic is the high rate of injuries and violent deaths among Aboriginal women, many of which are alcohol and drug-related.<sup>54</sup> Suicides by Aboriginal women are most common during the childbearing years (15-34 years).<sup>55 56</sup> Some studies have also shown that physical and emotional trauma of their male partners, are inflicted on these women more frequently and intensely during pregnancy.<sup>57 58</sup>

A number of studies, some of which included Aboriginal women, have looked at the general perceptions of high-risk pregnant women. In these studies, poverty and inadequate prenatal care were the main issues. Feelings of ambivalence, depression, low self esteem, unhappiness, and little control over one's life are common to women in poverty.<sup>59 60</sup> When one has to deal with life's hassles one day at a time, the unborn baby tends to get ignored. In fact, if the

pregnancy was unplanned, as it is in many cases, the pregnancy may be denied as long as possible. Seeking prenatal care early in the pregnancy would force the mothers to confront what they may not be ready to cope with.<sup>61 62</sup>

### **2.3.3 Issues Surrounding Utilization Patterns of Prenatal Care**

North American research has produced a considerable amount of work on the psychological and sociological factors associated with low-income pregnant women's participation in prenatal screening. However, studies that focused on the perspectives of women, their partners and families, are a relatively recent phenomenon.<sup>63</sup> Triplett states that there is very little information on how the poor perceive health services, and whether their perceptions influence health care utilization. Lia-Hoeburg states, "few studies have systematically sampled women from specific racial backgrounds by level of prenatal care. In addition, there has been a lack of emphasis on women's perceptions of prenatal care."<sup>64</sup>

The most common barriers to seeking prenatal care by high-risk pregnant women can be categorized in three main areas: structural barriers (e.g., inadequate finances, lack of transportation, and childcare needs), barriers related to socio-demographic conditions (e.g., young age, marital status, financial status, education level, and parity), and individual barriers (e.g., personal perceptions, personal issues).<sup>65</sup>

Some common perceptions surrounding prenatal care include fear-- fear of pregnancy, especially if it was unplanned, and fear of medical procedures. Many women who have sought prenatal care late in pregnancy report that they have had bad experiences at the prenatal care facility. They have experienced such things as being chastised for registering late, cold and uncommunicative staff, perceived racism, sexism, and hostility.<sup>66 67 68</sup> Most of these high-risk pregnant women also have multiple personal and family problems, along with depression, fatigue, and lack of motivation, which prevent them from seeking prenatal care. Most women know they should go but there are too many other

pressing problems, which are a priority in their lives. Some do feel that prenatal care is unimportant, probably because of lack of knowledge.<sup>69</sup> There are others, particularly Native women, who feel that as long as they are not sick, they do not need to see a doctor.<sup>70 71</sup>

In order to deal with the problems of Aboriginal children and their mothers, more emphasis needs to be placed on the needs of the mothers, in the hope that they may be more likely to focus on their unborn baby's needs. "Experts recommend that we replace the pre-occupation of current care with fetal well being with an equal regard for the daily concerns of the pregnant women as an integral component of maternal care."<sup>72</sup> For instance, Elbourne believes that the social and psychological support of pregnant women should be an integral part of care given during pregnancy and childbirth.<sup>73</sup> Indeed, several studies have indicated that support, assistance of loved ones, and encouragement and advice of others are very strong motivators to seeking prenatal care.<sup>74 75</sup>

Culture also has an important role to play in seeking prenatal care. The Ontario Native Women's Association says that many Aboriginal women want traditional midwives and healers included in their care.<sup>76</sup> They also want to receive pre- and post-natal care from their own people. Several pregnancy outreach programs that are Aboriginal controlled and have incorporated the teachings of the elders have proven successful.<sup>77 78</sup> The Aboriginal Nurses Association of Canada released a document framework that assists First Nations communities in Canada to design programs that improve the health status of children from pre-conception to age six.<sup>79</sup> This encourages families to start talking again about sexuality in the home at a young age and to teach their young about having pride in themselves and respect for each other.<sup>80</sup>

There is also a larger movement across Canada, in which Aboriginal women are taking control of their lives and their children's futures. These women want healing for themselves and their communities, and are seeking ways to do this (e.g., healing circles, restoration of women's ceremonies, elders' teachings

about the roles in the family, and the chance to rewrite the history of their people).

81 82

## **2.4 Current Perspectives of Pregnancy by Aboriginal Women**

I was unable to find studies that looked directly at the perceptions of pregnant high-risk Aboriginal women. Instead I found literature in the following two areas as I thought they would relate to the topic: historical views of Aboriginal women and ethnographic and anthropological research on values and belief systems surrounding pregnancy. The purpose for including this information was due to the cultural aspect of the participants' perspectives, which I suspect may appear in the findings.

### **2.4.1 Historical Role of Aboriginal Women**

Before motherhood comes womanhood,<sup>83</sup> and in order to have a better understanding of women's health, one cannot isolate the lives of women to one event, such as pregnancy.<sup>84</sup> "One must also have an understanding of the past to get control of the future."<sup>85</sup> Historically, Aboriginal women were healthy and highly esteemed and recognized by members of their societies, partly in their fulfillment of bearing and nurturing children.<sup>86 87 88</sup> In many societies, women were also seen as decision-makers for the entire community.<sup>89</sup> Teachings surrounding the roles and responsibilities of women came primarily from the mothers and other experienced women relatives.<sup>90 91</sup> These teachings started from an early age and followed into puberty. Different cultures had their own specific teachings during this sacred time on how to maintain a healthy pregnancy.<sup>92 93 94</sup> Young men were also taught their roles, including how to respect women.<sup>95</sup> Feasts, giveaways and ceremonies continuously reinforced these societal roles. Midwives, as well as holy men and women, were known to help out during the birthing process. The role of these helpers was extremely important on a personal, family, and community level.<sup>96 97 98 99</sup>

Today, Aboriginal families and communities are recovering from varying degrees of fragmentation and loss that have occurred over generations.<sup>100 101</sup>

Families are not the same as they were long ago; however, many Aboriginal people have managed to maintain a sense of their identity from the teachings of their elders, Mother Earth, their languages, and sacred ceremonies and traditions. Restoration of the family, its roles, and its health will be a difficult journey, but it is one that elders believe can be accomplished through a combination of modern ways and old traditions.<sup>102 103</sup>

#### **2.4.2 Ethnographic and Anthropologic Views**

Ethnographic and anthropologic studies have tried to gain insight into cultural perceptions related to maternal health of Aboriginal women. However, I could not find any studies that looked at culture-specific factors related to high-risk pregnant Aboriginal women. The studies, as well as some books written by Native authors, have focused on stories, values, and belief systems of Aboriginal women within specific Aboriginal communities. Sokoloski, in her study of urban First Nations women, found that a combination of Western medicine and traditional teachings surrounding maternal health was advocated by the Native women. Birth outcomes, however, still remained poor because of loss of identity, loss of pride in the role of women and motherhood, loss of the role of the father, loss of family closeness and support, increased prevalence of disease, poverty, lowered education, stress, lack of hope, and relationship problems.<sup>104</sup> In Bushnell's study in a Northwest Coast Indian community, women desired a healthy pregnancy but needed their beliefs to be respected, such as the spiritual aspects of pregnancy, and rules surrounding food and exercise.<sup>105</sup> Spirituality during pregnancy was seen as a demonstration of a higher commitment to maintaining the health and spiritual well being of the baby in Clarke's study of a Salish community in British Columbia. In this community, women were committed to traditional and common sense teachings during pregnancy, which



were given by the family.<sup>106</sup> Teachings such as these are also evident in books written by Aboriginal sources, which share stories of their people.<sup>107 108</sup>

Two notable things come out of the insights of the above studies: that traditional teachings still exist amongst Aboriginal people, and that their importance today may be underestimated by health care providers. Differences in commitment to the traditional and modern teachings during pregnancy between generations of women and between communities must also be recognized. All Aboriginal women are not the same. For instance, younger, urbanized women may tend to look to outside support during pregnancy (such as health programs and health professionals), while the older generations may tend to believe that teachings should come from the community women, except if a problem arises and outside help is needed.<sup>109</sup> In any case it is important to recognize the source of teachings. One unpublished ethnoscientific study by Horn suggested that, "the cognitions and perceptions of Native American Indian Women regarding pregnancy are virtually unknown to white middle-class health care workers."<sup>110</sup> She recommends research in this area, to look further into the women's social factors, cultural values, and motivational factors.

Verbal teachings of elders to this day offer advice and guidance related to maternal and family health to anyone who will listen.<sup>111</sup> These teachings touch the heart. They bring hope, direction, guidance, strength, and pride. They help Aboriginal women and families find out who they are and where they belong in this world so that they do not need to resort to drugs and alcohol. The teachings also offer love and acceptance and respect.

## **2.5 Perceptions of Pregnancy by Health Care Providers and Society**

The mother's role in today's society has been idealized and stereotyped, so that the woman is expected to accept and take full responsibility for the well being of her offspring.<sup>112</sup> Carrying this responsibility out involves seeking care during pregnancy as early as possible, as well as accepting and acting on advice

given by health care providers.<sup>113</sup> Health care providers' expectations also include the supportive role of the family, commitment to a relationship, responsible reproductive health care (e.g., getting PAP smears), and making rational decisions about childbearing (e.g., family planning).<sup>114</sup>

Those health care providers who give support and care to expectant women also have personal perceptions and expectations surrounding pregnancy and motherhood. According to Jensen and Bobak, a large portion of this comes from their own personal history: how they were raised, the values inherent in the lifestyle to which they are accustomed, their professional knowledge and their spiritual beliefs and culture.<sup>115</sup> It is likely that the perceptions of many health care providers, who are mostly white and middle-class, are very different from those of high-risk Aboriginal pregnant women.<sup>116</sup> Incongruity between these two versions of perceptions may be very important in determining the effectiveness of the support offered and accepted.

## **2.6 Pregnancy Outreach Programs in Canada**

There are approximately 257 prenatal programs in Canada which qualify as high-risk outreach programs.<sup>117</sup> These programs are geared towards high-risk families who are disadvantaged socioeconomically, demographically and/or psychosocially. Most of the programs are in urban centres, except in British Columbia where several exist in rural communities and reserves.<sup>118</sup> All of the programs are client-centered and aimed at improving birth outcomes, (e.g., preventing low birth weight).<sup>119 120</sup> Emphasized elements of the programs include knowledge and skill development regarding pregnancy and birth, healthy lifestyles, and physical well-being.<sup>121</sup> In British Columbia's 1993 Pregnancy Outreach Program Qualitative Evaluation Report, the most frequent reasons for women's involvement in the program were to gain emotional support for themselves and to offer support to the younger women through pregnancy. Others liked the food and the knowledge they gained on how to have a healthy pregnancy.

<sup>122</sup> A program in Whitehorse, Yukon was quite successful in their use of elders to teach the role of the 'traditional' mother.<sup>123</sup> Presently, that program has been expanded into two programs to provide the ongoing teachings after birth as well.

In 1983, Saskatoon's Healthy Mother Healthy Baby (HMHB) Pregnancy Outreach Program began in response to a study in 1979, which showed that existing prenatal programs were serving mainly low-risk pregnant women. In order to better meet the needs of the Aboriginal clientele, the program responded to the advice of an external Native Advisory Committee and hired a number of Aboriginal Pregnancy Outreach Workers.<sup>124</sup> At the time of this study, only one of these outreach workers was still employed in the program. There was also an Aboriginal nurse who worked part-time. Approximately 50% of the clientele are Aboriginal, although this fluctuates. All of the clients reside in Saskatoon, and are considered to be at varying degrees of risk for poor pregnancy outcomes. The program has been successful in reaching its target population, and its clients make significant improvements in reducing their high-risk behaviours. Woodard and Edouard, in their 1989 evaluation of the program, recommended further study in the area of community and client perceptions of the program and their health.<sup>125</sup>

## **2.7 Summary of the Literature Review**

The literature suggests that if high-risk Aboriginal women were asked about their perceptions of pregnancy, they might say one or more of the following:

### **Biomedical Factors:**

- a) I have been told that I have high blood pressure and I am diabetic. This really worries me, I wish I didn't have these problems.
- b) I don't understand why I have diabetes; I haven't done anything wrong. I guess I just have to accept it, I can't do anything about it anyway.

**Socioeconomic Factors:**

- a) Pregnancy? I have too many other things to worry about right now (poverty, relationship issues, family problems, and substance abuse).
- b) Worrying about this baby will have to wait until the time comes for its birth.

**Cultural Factors:**

- a) Being pregnant is a gift from the Creator. My mother and aunties have taught me my responsibilities. I have their support and I am doing my best to live up to their teachings.
- b) Those old people, all they tell us are old wives tales. They don't understand what it's really like today, what they say doesn't matter much to me.
- c) I wish I knew more about my culture, and what I am supposed to do during my pregnancy.

**Feelings about Prenatal Care:**

- a) I want to take care of this baby, but I don't like seeing the male doctor, and the nurses always seem so rushed and kind of cold.
- b) I don't see why I need to go to all those appointments when there's nothing wrong, I am not sick.
- c) I wish I could go to all my prenatal appointments, but I have the other children to look after and my partner won't take me.
- d) I wish everyone would leave me alone. This pregnancy is my business. Drinking didn't hurt my friend's baby.

#### Urban Issues:

- a) My children are lonely for their relatives, and I don't really know where to go for help.
- b) I'm really glad to get away from my reserve, now I can have a home where I feel safe and I don't have to worry. But I'm still lonely.

#### Perceptions of Pregnancy Outreach Programs:

- a) I get a lot of support from the other women in the program and that means a lot to me; I don't feel so alone. The food vouchers really help out too.
- b) I especially like the traditional teachings. They help me to feel special and proud to be a mother, and help me cope with my problems.

#### Perceptions of Aboriginal women's issues in general:

- a) I want to take control of my life, stop the cycle of abuse and do what is right for the future of my children.

Are these the only themes associated with the perceptions of pregnancy amongst high-risk Aboriginal women? Or are deeper themes and meanings attempting to surface? Is there an aspect about their perceptions of pregnancy that could bring their experience more fully into our presence? Is there something essential that we as health care providers need to know about in the experience of pregnancy for these women? Has how we 'see' these women's health obscured the lived meaning or significance of their experiences with pregnancy? Some researchers have alluded to the need to look deeper into the perceptions of these women in order to have a deeper understanding of them, especially as it relates to preventative maternal care services. That is the purpose of the present research.

## **CHAPTER 3: METHODOLOGY**

### **3.1 Qualitative and Phenomenological Approach**

#### **3.1.1 Qualitative Research**

Qualitative research focuses on the humanistic, holistic and subjective nature of human beings. This form of research complements quantitative findings by its rich descriptions and insights, which help to provide answers that quantitative data may not be able to give us. The inductive process of qualitative research allows theory to emerge, as well as the identification of new paradigms, hypotheses, variables, directions and theoretical frameworks.<sup>126</sup> This study utilizes a phenomenological approach.

#### **3.1.2 Phenomenological Research**

I chose phenomenology because it suits my way of thinking. I like to ask questions and challenge the status quo, particularly when it pertains to the complexities of human beings. Phenomenology allows me to question further, and look for a fuller awareness of my assumptions of people.<sup>127</sup> Phenomenology puts our knowledge in doubt or on hold. It says, “think again,” that maybe we can come to a fuller, richer understanding of our clients, and ourselves and how to assist them. There is no one phenomenological method, or one consensual, univocal interpretation,<sup>128 129</sup> however, all varieties of phenomenology hold to the primacy of the subjective. “What is this experience like?” it asks, looking for the fullness of living.<sup>130</sup> In this study, the focus is not on the prevalence of high-risk conditions or events during pregnancy, but rather on the nature of the experience of pregnancy itself. “Phenomenology is concerned with meaning-conferring acts rather than the specific contents of experience.”<sup>131</sup> Van Manen encourages researchers to question the nature of the phenomenon, which in this study is the perception of pregnancy, as an essential human experience.<sup>132</sup> In this manner, I am

hoping that this phenomenological study of the perceptions of pregnancy of high-risk Aboriginal women will make the distinction between what appears to be important and what other things might be important, but may be being left unsaid in the literature review.

### **3.2 Site Selection**

Saskatoon, a city of approximately 200,000 people in the prairie province of Saskatchewan, was the site of this study. According to the 1996 census, the highly transient Aboriginal population made up approximately 7% of the city's total population.

### **3.3 Sampling**

Sampling was purposeful in order to yield the highest understanding in a short period of time. The sample consisted of five clients of the Healthy Mother Healthy Baby Pregnancy Outreach Program (HMHB POP).

#### **3.3.1 Selection Criteria**

All five clients were of Aboriginal ancestry, and were considered at high-risk for poor pregnancy outcomes, and were thus eligible for entry into the HMHB POP. But once in the program, they were again assessed for the degree of risk, called the prenatal risk category: low, medium or high (Appendix A). I was unable to choose women who were in the same degree of risk because of a lack of a sizeable number of participants to choose from. See Appendix B for the prenatal risk summary profile of each participant. The characteristics that were common amongst four of the participants were single parenthood, financial challenges, and relationship difficulties. All of the women were between 21 and 25 years of age. I purposefully chose to eliminate pregnant teenagers and older women because of the uniqueness of their needs during pregnancy.<sup>133</sup> Each woman was interviewed

during her third trimester to allow her greater opportunity for reflection on her pregnancy.

### **3.3.2 Selection Process**

Qualities of a good informant include their knowledge of the topic, as well as their ability to reflect and give detailed experience and descriptions.<sup>134</sup> It is also beneficial if they have tolerance and patience to talk with a stranger about personal issues. Pregnancy outreach workers had already developed a rapport with the clients, and were the gatekeepers in the selection process and in gaining access to the clients.<sup>135</sup> They were asked to recommend as many clients as possible who would be willing to divulge information that is rich and descriptive. Clients who would be chosen were most likely to be regular attendees to the program, which leaves out the reflections of the ones who for some reason left or lost contact with the program.<sup>136</sup>

Outreach workers gained the clients' permission and gave them an idea of who I was, and what I would ask. Then they gave me a list with some of the clients' demographic data including their prenatal risk category. Having the outreach workers ask the client about participating, and telling them about me helped, but the number of willing participants was low. This could be due to the probing and personal nature of the study.

In total, I selected five participants from a total of 14 potential names. The first three participants came from a total of six clients' names that were given to me gradually between October and December. I selected these three because they were the most interested in the project and clearly willing to participate. I had difficulty getting further names after this. The Director of the HMHB program tried to assist me by recruiting participants by phone. Four clients said they would be interested in participating in the study. However, when I approached these women at their homes, they did not follow through, possibly because the outreach workers did not sit down with them and explain what the



study was about, or who I was. Finally, in March, I had to elicit the help of the Native outreach worker, who took me to meet four of her clients. She introduced me to them and allowed me to explain the study. I then left the premises to allow the outreach worker to complete her visit with the client. A couple of days later, I followed up with a phone call to the clients to maintain the participants' anonymity from the outreach worker. Though all four women seemed willing to participate in the study, I selected just two in order to prevent the outreach worker from knowing who the participants were. It seemed that the women's willingness to participate improved when I was introduced to them in this fashion.

Initially, I had hoped that I could have received a pool of names from the outreach workers. I was then going to code their names and take them to the sweatlodge for selection. However, as a result of the difficult process of finding clients, I was not able to do this. Upon advice from the elders, I chose to sweat and pray for all the mothers and their babies whose stories were ready to be heard. In other words, women who eventually would be selected would be the ones 'meant' to be in the study. This request was made in private to the elders with no names mentioned at any time.

There was no problem in gaining access to high-risk pregnant Aboriginal women from the Healthy Mother Healthy Baby (HMHB) program in Saskatoon. All of the women were accessible by phone and within city limits. I had my own transportation which helped, as several times the women were not at home or unable to see me when I arrived at their place. Overall, the women seemed glad to participate in the study, and I felt free to call them at any time by phone. They quickly remembered me on a first name basis. They also appreciated the gifts, which I gave the women and their babies in exchange for the gift of their stories.

### **3.4 Data Collection**

#### **3.4.1 Personal Starting Point**

Van Manen recommends that the researcher start by giving the reader a personal description of his or her lived experience, without offering causal explanations or interpretation.<sup>137</sup> The purpose of this is to help me be aware of my own experience of this phenomenon of pregnancy which may be able to “provide me with clues for orienting the reader and myself to the phenomenon and thus to all the other stages of phenomenological research.”<sup>138</sup> I will attempt to do this in the following.

I was not prepared to be a mother when I first became one at 27 years of age, but I jumped into the role because I knew how to be one. My mother taught me about being a mother. My mother is Native, and my stepfather is from England. Motherhood memories are fond memories to me. My mother stayed at home to care for me, cooked me warm meals, took special care of me when I was sick, gave me lots of attention, and taught me how to cook, clean, sew, crochet and knit. My mother was quiet, gentle and kind. My father taught me how to be independent and self-directed. When I became pregnant the first time, I immediately bonded with my baby in a spiritual way. My spirituality gave me strength and guidance during this difficult time. Specific knowledge of what to expect during my first pregnancy came from my knowledge as a nurse and from friends. I did not learn this from my mother. We did not discuss personal issues of womanhood.

I coped really well during all my pregnancies, my babies were healthy and I was healthy except for high blood pressure and excessive weight gain. I don't know what I would have done if something had gone really wrong because I was basically alone, physically and emotionally. My partner was alcoholic and abusive. I learned a lot about myself during my relationship with him. I'm happy

to say that my perceptions of my last pregnancy were particularly special as I had the support and care of a midwife and traditional elder. I had the best of care, emotionally and physically, and they enabled me to have my baby at home. This meant a lot to me because I needed to feel some sense of control over my circumstances. Also, I did not have to leave my children and their adjustment to the baby was wonderful. The midwife and elder continue to be a support for my family. The special bond that we have means a lot to me; it's like my family has been extended, and I don't feel so alone. I'd like to be able to reach out to women and support them in this way during their difficult times.

Feedback on the effectiveness of the personal starting point in orienting the reader to my own perceptions of the phenomenon of high-risk pregnancy was received well by my supervisor and thesis committee. It also helped me to understand where I was coming from after being away from the research for nine months. During the nine months that I was away, I was in a leadership position in my home community, dealing directly with Native health issues, including the ones similar to this study. My work experience has since assisted me in gaining objectivity, and personal and professional maturity.

When conducting phenomenological research it is important to identify and lay aside pre-assumptions and prejudgments about the research as much as possible. Van Manen explains:

The problem of phenomenological inquiry is not always that we know too little about the phenomenon we wish to investigate, but that we know too much. Or more accurately, the problem is that our "common sense" pre-understandings, our suppositions, assumptions, and the existing bodies of scientific knowledge predisposes us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question.<sup>139</sup>

Though the hypotheses emerge during the process of phenomenological research, preconceived ideas about the study are naturally present due to the researcher's background and interest in the study. Since I am Aboriginal and shared many of the circumstances of the sample group at the start of the study, I already had strong ideas of what they might say. For instance, I expected that the perceptions of these women would involve thoughts relating the mind and the spirit. In this case, I thought that emotional and spiritual healing might be strong determining factors towards accomplishing optimal physical health and a reduction in risk factors. I saw local elders supporting this, believing in the importance of inner healing through the teachings of one's culture.

I also believed that the findings of this study might validate some of the approaches of current prenatal health care services, particularly in the HMHB program, and that they might also show the reader that these services have legitimate boundaries. I believed that programs run primarily by non-Aboriginal people might be limited in their ability to 'help' the Aboriginal clientele. In this case partnership with or support of a local Aboriginal healing initiative would be more effective towards supporting these women and their families. These were possibilities in my mind and I continually tried to remind myself that the participants' perspectives might turn out to be entirely different.

According to McCarthy, researchers need to state their assumptions regarding the research under investigation, and bracket them, in order to fully (try to) understand the experience of the study and not impose a priori hypotheses on the experience.<sup>140</sup> I expected this to be a challenge for me. In a way my knowledge and life experience could be a limitation to the study if I am unable to convince the reader that the findings are not a confirmation of what I expected. On the other hand, being Aboriginal, a single parent, poor, and from an abusive relationship may have helped me to acquire information that the participants would normally feel uncomfortable about giving. I was willing to share this basic

information with the clients, however, I preferred detailed life experiences to come from the client's own stories.

One comment that I frequently received from colleagues about my research was that because I am Aboriginal, these women should really open up to me. I want to clarify that my upbringing by a non-Aboriginal stepfather, my inability to speak my Native language, my level of education, and the participants not knowing who I am or who my family was (I'm not from this province), might in fact have brought a sense of mistrust by the clients. I tried to be sensitive to this as I collected the data. This is one reason why I sought the advice of elders for this research, at the beginning.

### **3.4.2 Interviews**

All of the interviews were held in the participants' homes, except for one or two occasions when we met in a restaurant to edit and clarify the transcripts. Data was collected in four to five visits per participant. Their length was one to one and one half hours on average. During the first visit I introduced myself, went over the participant information form (Appendix C) and consent form (Appendix D), reassured her of confidentiality, and left her with the questions to review (Appendix E). I felt that it was important to give her time to think over the questions before we talked about them. This was more of a cultural consideration, as I did not want to embarrass her by demanding an immediate answer that may have required much thought. On the second visit we signed the consent and I took it to get it photocopied and gave her the original copy. During that same visit we began the interview using a tape recorder. The third meeting was to give her the transcripts to review, and on the fourth meeting we went over any editing or clarification of the transcripts. The fifth visit was intended for us to validate or correct my interpretations of the data. But seeing how I was unable to do this, (as I will explain under "analysis of data"), the fifth visit became the time that I met

the baby and took them their gifts. I also gave some of my second-hand baby clothes to some of the mothers, which they greatly appreciated.

The interview with the second participant occurred before the completion of the analysis of the first; however, subsequent interviews were done after the completed analysis of the first two interviews. The reason for this was that I anticipated something to evolve out of the data that I may have wished to explore in particular, and also for the purpose of data management.<sup>141</sup>

The researcher is the key tool for acquiring data for this study,<sup>142</sup> and there were several considerations that I had to be aware of and to deal with ahead of time. I felt that being Aboriginal and having knowledge about traditional culture should have helped to some degree in the interviewing process for some of the clients. I found that it helped to not to be too pushy, too direct, or too invasive with my mannerisms (eg., eye contact). I was friendly, humorous, and comfortable during times of silence, I talked quietly, and tried to be non-threatening. I explained who I was, where I was from, what I was doing and why. I offered a trade for their time (money, food, or whatever they preferred), as well as a gift to mother and baby (on the advice of the elders). All of the women seemed to appreciate the traditional measures that I incorporated into our meetings. The Native outreach worker seemed the most knowledgeable as to how traditional the clients were. Four women accepted the tobacco, and one woman used the talking stone during the interview. All of them accepted the money and gifts for mother and baby that were donated gift products from the Body Shop.

I did share a little of my experiences at times with the clients, in terms of being a single mom, having had four babies of my own, and being a nurse. However, I tried to not focus too much on this, as I wanted them to do most of the talking. I knew that if I talked too much, they would become quiet. Most of what I said about myself was at the beginning during the initial meeting to help them understand who I was and why I was doing the study. They seemed to open up to me and quickly became comfortable with me. I felt that the women answered me

freely, and they did not seem to worry about what kind of response to give me; they were not looking for approval in their responses nor were they fearful of being judged by me.

Some women did look to me for advice, mostly relating to their upcoming delivery. Occasionally they asked questions such as how to bring on labour naturally to avoid being induced, and how to relax and concentrate during labour. One woman phoned me from the hospital and asked me to pick up her and her baby to drive them home, which I did.

#### **3.4.2.1 Interview Questions**

Since phenomenology is concerned with meaning-conferring acts rather than with the specific contents of experience, “The questions should address acts of consciousness such as perceiving, empathizing, intuiting and the like.”<sup>143</sup> In order to get data such as this, the participants would need to be in the actual experience of pregnancy during the time of the interview. I thought that it would be difficult and the least reliable for them to answer such deep and probing questions if they had to answer retrospectively. Though the participants were in the actual experience of pregnancy at the time of the interviews, the issues, thoughts, concerns that they expressed did not revolve around the actual experience of pregnancy, but rather other issues which did involve retrospective thinking. Please see Appendix E for the initial questions that were used in the interviews and how I changed the focus of the initial overall question.

Van Manen emphasizes that the phenomenologist must be able to draw the reader of the research into the question, and wonder about the nature of the phenomenon in the same way as the researcher does.<sup>144</sup> Phenomenological questioning teaches the reader to wonder. The questions in this study were broad, following the developmental phases of motherhood from the participant’s experience starting as a child, to her being a woman and a mother.<sup>145</sup> Almost from the first interview I noticed that further questions did evolve, and I did need to

return to the previously interviewed participant a number of times to question them on these.<sup>146</sup> I noticed that since the participants were talking about their upbringing and present lives, it seemed quite natural to begin to talk about hopes and dreams for themselves, their offspring and the relationships with their partners. It turned out that this information became the significant findings of this study. Thus I felt that the questions that I originally posed were broad enough and effective starting points for stimulating further discussion in other areas.

I had difficulty getting the participants to offer lengthy examples of experiences that they had. Throughout all of the interviews I felt some discomfort with probing them too much for their experiences, sensing that the information that I was asking for was too personal to tell me at the time. I felt like I was prying, and it is not in my nature to do that. For this reason the data is not as rich and descriptive as it could have been. Towards the end of the last interview I felt more confident about interviewing. Perhaps the reason for this could have been that I had gotten to know them better by this time.

Another reason why the answers to my questions could have been lacking in depth was due to the distractions that took place in the homes at the times of some of the interviews. Sometimes their children and other members of the household were present. Whether or not the participants could be considered good informants is questionable. None of the participants said they really thought about the questions before I interviewed them, even though they had the opportunity to reflect on them.

To assist in keeping the interview process on track I used a tool developed by Dr. John Bird, called The Awareness Wheel (see Appendix F). I used this to focus and refocus the participant on her perceptions and feelings. Thoughts and actions relating to pregnancy can be mentioned but it is imperative to stay as close as possible to experience as lived.<sup>147</sup> I asked the person to think of a specific instance, situation, person or event, and then I attempted to explore the whole experience to the fullest. If for some reason I felt that the participant did



not like me or was not able to give the descriptive information that I needed, I was prepared to approach someone new.<sup>148</sup> This happened on one occasion where a participant changed her mind about being in the study.

After interviewing the first three participants, my supervisor suggested that I approach the questions differently, changing the order of the communication tool I used (Appendix F) to begin with their experiences and thoughts, then follow this with perceptions and feelings. I found that this approach worked much better as I applied it to my last two interviews. The reason for this was because it seemed more difficult for the participants to offer perspectives and thoughts about an abstract idea compared to a specific experience in their lives.

Fontana and Frey talk about the possibility of a closer relationship between the interviewer and interviewee. As long as assumptions and premises are clearly stated, some researchers feel that a closer, more open and 'human' approach on the part of the researcher will allow the participant to express herself more fully and will also do away with some of the traditional hierarchy in interviewing.<sup>149</sup> I thought that this form of interviewing would be appropriate in this study; however, I had to be extremely careful not to cause acquiescent or socially desirable responses. I have covered how I dealt with this under "Trustworthiness" in section 3.8.

Another way in which my knowledge and experience in the topic area may have had an effect on this study is in the way that I asked the questions. For instance, what I knew about the topic could have been the basis for assumptions that could have precluded me from seeking explanations and that would have shut down any depth-probe inclinations; "if you second-guess your respondents, then you forego the chance to say, tell me more."<sup>150</sup> I was aware that I was not well versed in interviewing, except in nursing history taking and assessment, in which case I usually knew what I was looking for and I would follow a strict format. In this study the theory or insight was supposed to evolve in the process of interviewing and I was keenly aware that I had a problem with second-guessing

people. While conducting the interviews, I took special effort to sit and listen, clarify what I heard and attempt to be a true learner. I tried to not dominate the interview except to keep the participant on track, and I tried to patiently probe the participant for more details.<sup>151</sup>

Time is also an important element in interviewing. Glesne and Peshkin advise the researcher to give unrushed attention and deliberation to the responses. "Rush and the world rushes with you."<sup>152</sup> My manner of questioning was unhurried, allowing for long pauses and reflections and relaxation, except for times when there were noises and distractions occurring. During these times I had a tendency to lead the questions and answers a little more. I made note of these both in my field notes and in the transcriptions, and referred to them again with the participant for clarification during the editing.

As part of assessing my interviewing skills, I conducted a pilot interview with a pregnant Aboriginal woman who had recently delivered. I timed the interview and asked the volunteer to critique the questions in terms of their clarity, and appropriateness. I had my supervisor review a tape of my pilot interview before I began the interviewing of the participants.

### **3.4.3 Personal Journal and Field Notes**

Subjectivity on the part of the researcher plays an important part in data collection and analysis. Glesne and Peshkin suggest that the researcher construct a subjective map of the self, which will come out during the experience of researching the participants.

I was aware of the course of data collection, and thereby alerted as I proceeded to analyze and write up my data, of what within me was operating to shape, skew, distort, construe and misconstrue what I was making of what I saw. My hope was to tame my subjectivity, to know it well, to get in shape, so that I

could use it in its virtuous capacity, while minimizing its negative potential.<sup>153</sup>

My field notes consisted of the descriptions of the interview using my senses, reflection of my feelings, personal things I learned, and the triggering of new ideas and memories as they related to the study. These were written down immediately following the interview and labeled with the date and the portion of the study it was referring to. These notes were stored at home to protect the anonymity of the participants.<sup>154 155</sup>

I found that my personal biases came out throughout the entire process of the research. I was diligent in keeping an in-depth and dated journal of my thoughts and feelings and even the reactions of others to this research. For instance, when I asked my transcriber her thoughts of the interviews she just shook her head and said, "Trouble, so much trouble". I found her reaction to be annoying, as I did not view these women in this way at all. I also found other people reacted in the same way as her when I told them the area of my research. I wondered why my reaction was so different from theirs. At the beginning of this project I saw these women as dedicated to their families, and to be strong and capable deep inside. I saw them as the primary 'keepers' of Native families and generations in a time where Native fathers were greatly absent. I saw a part of myself in them. I saw no reason to pity these women; to me it took away their hope, dignity and vision for their lives and their children. Perhaps by seeing myself in them I did not want to admit their weaknesses. For instance, when one of them admitted to smoking marijuana, my temptation was to 'ignore' that piece of information, and focus on her more positive attributes. Another example was my disappointment at not finding participants who shared reflections on spirituality or self-awareness during of their pregnancies.

During the process of this research I have been forced to look at these women from several different perceptions other than my own. I have had to acknowledge the perceptions of these women and the study by non-Native and

Native health care providers, my thesis committee, colleagues who I bounce ideas off my transcriber, the women themselves, and the elders who have commented on my findings. This has been an eye opener for me and I feel that if I have learned to do this well, I will have learned a lot about research and life itself.

### **3.5 Time Line**

I completed the interviews between October 1998 and April 1999. The interpretation of my findings was carried out between April 1999 and November 1999. I returned to work on my thesis nine months later in September 2000 having moved to another province in the interim to begin a new job.

### **3.6 Analysis**

The analytic process in qualitative research involves the movement from description to the explanation of meanings.<sup>156</sup> The inductive process for this study was primarily based on a combination of approaches using the following four steps (Appendix G):

1. First I read the transcribed data and field notes carefully to get a feel for them.<sup>157</sup> This was done to make intuitive and initial sense of what had been said,<sup>158</sup> and to be alert to my own biases, judgments and subjectivities.<sup>159</sup> The interview transcripts were edited and clarified by the participants. At times there were data gaps, and areas where I led the questioning, or made statements which were judgmental or subjective. I made note of these in my field notes, and on the transcripts and wherever possible I asked the client to clarify or expound on these areas during the editing. At one point I had to leave the unedited transcripts with one woman to go over on her own, because there were several spots where her voice was too quiet for the tape recorder to pick up, and she filled in the blank spots.

2. I then read over the field notes and transcripts again several times before I started to categorize the statements. I then used a process to extract significant statements that directly pertained to the investigated phenomena, and made note of the rationale for doing so. I numbered each line of the transcripts. Each sentence or groups of sentences were categorized either as a thought, feeling, perception or experience. I then did as Van Manen suggested, using the line-by-line approach, where I looked at each sentence and asked what this statement revealed about the experience being described.<sup>160</sup> Repetitions and similar expressions were eliminated.<sup>161 162</sup> Though the data was not rich in description and experiences, there were commonalties of thought which I felt stood out across the participants.
  
3. The interviewee's statements were then clustered into themes and validated with the initial description.<sup>163 164</sup> The themes were contrasted and compared keeping in mind intervening variables.<sup>165</sup> The collected data was sorted and defined into major code clumps and sub-codes, (Appendix H) and placed into a meaningful sequence to contribute to the chapters of my findings.<sup>166</sup> Using this process I extracted five themes with headings under each theme. I gave rationales for choosing these themes, and pointed out areas of discrepancies. I submitted the themes to my supervisor after interviewing the first three participants, for validation purposes.<sup>167 168</sup> She agreed to my findings and their significance and offered suggestions to my interviewing technique for the last two participants. She also stated that she could 'feel' from the interviews, sensing the longing and hopes of the participants, but yet they did not really have what they wanted. This made me feel good, as I had the same feeling about these women. In September 2000, when I returned to the research after nine months away from it, I streamlined the five themes into three major themes that I felt were the most significant and central to the understanding of the participants' perspectives.

4. I wrote up the data in the three themes and under each theme I gave descriptive examples in the women's own words.<sup>169</sup> I also included my own comments on their significance as they related to the literature, my experiences and the input of the elders.

It is true that the discussion of the themes were my own interpretations. Some of the discussion came from the elders, though their input was limited as they did not read the transcripts. Therefore, they only heard my interpretation of the findings. It is possible that if they had read the transcripts, the themes and the overall interpretations could have been quite different.

I approached two local Native women elders who were familiar with this population group, to help me with this important section of the study. These are the same women that I went to for advice at the beginning of the study. I have been updating them on my interpretation of the findings in terms of the themes, and I have been asking them to comment on them. I also asked them for suggestions for pregnancy outreach programs. Both of these elders live in the city and work on a continual basis with Aboriginal peoples here, including young high-risk women. They both are respected teachers of Cree cultural teachings, traditional parenting and ceremonies, and have extensive knowledge and wisdom about social issues of Aboriginal people. I felt that their input would be valuable towards the practicality aspect of this project, since one of the main reasons for doing this research was to gain further insight into the perceptions of high-risk Aboriginal pregnant women, which in turn may be used as a means to improve health promotion programs.

One elder met with me specifically to 'talk' about my findings, on July 1, 1999. She offered me valuable insight into these women's lives as well as what she felt they needed. We have also had discussions since then which were less formal. Her style of teaching is more in a story format, so it took several visits to gain the insight that I needed. I also met with another elder on other occasions to

hear teachings. I did not audio-record any meetings, but rather took down notes of what I could remember.

A summary or conclusion to this study will not be evident and the findings will not be generalized. If the descriptions are powerful enough, they will be transparent, permitting the reader to see the deeper significance or meaning of the lived experience. As Van Manen suggested, it is tempting to look for a summary or conclusion of a phenomenological study.

When you listen to a presentation of a phenomenological nature, you will listen in vain for the punchline, the latest information, or the big news. As in poetry, it is inappropriate to ask for a conclusion or a summary of a phenomenological study. To summarize a poem in order to present the result would destroy the result because the poem itself is the result.<sup>170</sup>

The sample was so small and my ability to gain a true picture of these women was constrained by lack of time and lack of opportunity to really get to know them.<sup>171</sup> What I read and heard about the participants through the outreach workers, and what I heard from them during my few visits serves as a powerful restraint to make any sort of generalizations. The outreach workers may have 'seen' a lot more than I did, but I was not able to get their input on each participant due to confidentiality constraints. Health care practitioners may be interested in the discussion of the themes, and the suggestions for program development, as new concepts not previously seen or fully appreciated have been investigated.<sup>172</sup>

In summary, the analytical attention must be on the research process, making sure the method is sound. I could not guarantee that this study would produce significant results, but I hoped that it would provide some understanding. My findings are neither definitive nor certain, so as such they are not an end unto themselves; they are simply a stimulus for new ideas and a means of looking at

these women perhaps in a new way. It is also my hope that new ideas will be generated from this work, and from these, the inspiration of new work in this area will come about.<sup>173</sup>

### **3.7 Ethical Considerations**

My first responsibility was to the participants: the protection of their welfare, dignity, and anonymity. It was a privilege on my part to obtain this information and to be able to use it for my research. I focused on respecting the participants and being honest in explaining how this research would be used and what my role as a researcher was. These were explained in the consent form (Appendix D).

### **3.8 Trustworthiness**

A number of approaches were used to produce trustworthiness in analysis and interpretation of data. For instance, the analysis of the data was consistent and logical, allowing for credibility and confirmability in the data, and in my conclusions of the analysis.<sup>174</sup> The quotes and descriptions provide evidence that things were the way I reported them to be. My supervisor reviewed the coding and themes to ensure that conclusions and recommendations were truly supported by the data. Dependability was shown through an audit trail on how decisions were made in the process of the study. Reliability is the fit between the researcher's findings and what actually occurred in the situation under study. If another person conducted this research, they may have found new perspectives, but what actually occurred should have been the same.<sup>175</sup>

Researcher bias cannot be eliminated, however, my ideas and views can be revealed by my field notes.<sup>176</sup> When the researcher is the instrument, all data must be filtered and processed by the researcher. All my beliefs, values, knowledge, experiences, emotions (self assumptions), and customary way of



processing sensory input, have been documented in the notes to be identified and bracketed and set aside.<sup>177 178</sup>

Adequate time was also needed for acquisition of trustworthiness and to gain a sound relationship with the respondents.<sup>179</sup> With time, they are more likely to be frank and less likely to change their behaviour in the researcher's presence. It also increases trust, reducing socially desirable or acquiescent responses. Social desirability means the participant gives the response she believes the researcher wants;<sup>180</sup> this is why I was careful in not displaying my views too much or giving approval of what participants were saying. Acquiescent response means the participant consistently agrees or disagrees and basically gives responses that mean nothing. The best way to deal with this is to do interviews over time. Since limited time was a factor, this was a limitation of the study. I tried to help to correct this by not asking yes or no questions, but rather open-ended questions to which there is no right or wrong answer.

I also used triangulation of data collection and interpretation by comparing their responses in the interviews with information from HMHB POP, and the information from the picture probe (Appendix I). As well, I tried to clear up inconsistent statements that were made during the interviews.<sup>181 182 183</sup> All of the participants seemed to be answering me truthfully, in that I did not find any major discrepancies between the difference sources of data.

## **CHAPTER 4: RESEARCH FINDINGS**

### **4.1 Introduction**

As I previously mentioned in the introduction, the findings do not reflect the initial research question, which was to learn about the participants' perceptions of pregnancy. When I began to question the participants, they were more interested in discussing other areas of their lives, as the reader will see in the following themes. In this chapter I will present my findings organized under three themes: A Woman's Need to Love and Be Loved, A Good Family, and Personal Growth and Ambition. All of the themes are included under one overall theme called 'Hopes and Dreams.'

### **4.2 Description of Participants**

The actual ages of all five women were between 21 and 25 years. They were heads of their own place of residence— four in apartments and one in a low-income duplex. Their living conditions were very sparse, with just the essential pieces of furniture, except for one (Barb) who had plenty of knick knacks and a cozy environment. All were collecting social assistance, and four were supporting their boyfriends. Only two had a high school diploma. Four participants had children, three of whom had children with different fathers than the current father. Only one did not have an upbringing whereby she experienced some form of neglect or abuse from their caregivers. None of the women had an upbringing with traditional Aboriginal teachings and ceremonies. See Appendix J for a summary of their description, and Appendix B for a summary of their HMHB high-risk scoring.

### **4.3 Themes: Hopes and Dreams**

The literature focuses on several characteristics of women and their families who live in poverty. Most of these characteristics have been described in terms of negative behavioural and environmental risk factors. Though these factors are valid in that they show a certain side of the overall picture of these women, as one of the participants in this study stated, "Sometimes the right questions just aren't asked". She stated this as she was leaving the first interview, telling me that she really enjoyed sharing, and how it made her "feel good". During our interview she had time to express some of her inner feelings, hopes and desires. Studies in the literature do not talk about the hopes, dreams and aspirations of high-risk pregnant women. This type of discussion may seem 'unrealistic' or too subjective in nature; however, the general questions posed in this study seemed to lead to topics in this area. One might wonder why the hopes and dreams of this group of women would be significant; however, I see the acknowledgement of these findings to be directly relevant towards culturally based program development. This will be discussed in the next chapter.

The following looks at my findings. I found three themes, all of which I headed under 'hopes and dreams'. The reason for placing them all under this heading was because their lifestyles did not really manifest what the participants had claimed to be important to them.

#### **4.3.1 A Woman's Need to Love and Be Loved**

The literature shows that many high-risk pregnant women struggle with the burden of caring for children because of issues related to poverty and lack of support. In fact, some high-risk women live in denial during their pregnancy, due to the inability to cope with the realities of the upcoming birth, and some even consider abortion. These women were quite different. Even though they have suffered many hardships, such as having had to quit school, and being poor, they were all very pleased to be pregnant. This surprised me, and as I listened to them, they gave me some insight as to the reasons why.

I learned as well that the boyfriends of these women were all pleased with the pregnancies, though at times some of the fathers expressed uncertainty as to whether or not they were the true fathers. All of the mothers mentioned the positive aspect of having babies, in terms of having someone to love and having someone to love them. In fact, I did not hear one expression of disappointment of them being pregnant. The time of disappointment may come later when the stresses of the mother and child relationship become more evident.

### **Feelings of happiness**

Even though Anne had to quit school [again] because of this, her second pregnancy, she still was happy about it. When I asked her, "What was it like when you first realized you were pregnant?" she responded by saying that she was "shocked and happy." Barb also expressed her joy of being pregnant, and feeling a sense of readiness for this experience. "I'm very happy with myself. I find that I'm well prepared for the baby, and I'm happy I'm having a baby. I got used to the idea of being a mother [during her last pregnancy] ...you know just making plans ...I was...I finally learned to accept it, and I was happy in my last pregnancy. And after... after I had my miscarriage, like I knew then that if I was to get pregnant again that I would have the baby."

### **Pride**

Having a sense of pride and accomplishment is important to everyone. For Aboriginal people, being pregnant and having children is generally viewed as something positive and to be proud of. Though Anne had an unsupportive relationship with her biological mother, she could still count on the recognition of her children as being a source of pride, even from her. "She [her mom] just kind of make me, I don't know, not to be proud of myself, like not to be proud of I'm a woman, I'm a girl...like I have nothing to be proud of, except my kids." Ella refers to having a baby as a source of pride by stating, "... you [meaning women] can have babies, and feel life growing inside of you and men don't have that.

They can't experience what it's like to have a baby growing inside of you, the men."

### **Someone to love me**

Having someone to love us is essential to our growth and purpose in life. For women in situations of hardship, where there is a feeling of limited control over one's life circumstances, having babies could be a powerful source of unconditional love. "I was happy because I was going to have something that's going to replace like...another thing that'll make me happy in my life instead of depending on one thing [she was referring to her boyfriend], might be another thing?" Anne later clarified this point by stating that she wanted, "...someone to love me back. I was bringing something into this world to love me and love me now."

Deb also stated how children are a source of love for herself, "...having loving kids (chuckles)", and "... kids loving their mother," are what she saw as meaningful to being a mother. Fran, who was raising two young children on her own, gave her positive reflection on motherhood, "Just being a mother, makes me feel good. Just being there for someone close to me."

### **4.3.2 For a Good Family**

The literature talks about the neglect that children suffer from high-risk mothers and/or poor families. Though this may be true, researchers have failed to recognize high-risk mothers' desire to be there for their children. As was seen in the interviews, this was an important thing on their minds because they all (except for Barb) suffered some form of abuse or neglect as children. This is what stood out in their minds at this time in their lives. A further component of this, which I felt was significant, was their desire to have good families, including good relationships with their partners. The literature mentions that high-risk pregnant women frequently do suffer from abusive partnerships and relationship problems.

The actuality of a good family living situation was not evident in most of the participants' lives, but the desire for one was there. How strong that desire was, was difficult to determine, however, I will explain how I see the desire itself as significant.

### **Relationships with their children**

Some of the women talked about their lack of closeness with their mothers during their childhood. They all expressed sadness with this, though in some cases other people in their lives did try to compensate for the lack of attention and nurturing from their mothers. This type of upbringing seemed to be significant towards molding their current belief that children should always have their mother 'there for them'. For example, Anne stated, "No, I never had that feeling [of being mothered]. I always felt alone with no mom. Nobody treated me like their own... they just treated me like one... like another ordinary kid, not like their own." In the second interview she said that her sister was like a mother to her for awhile, and that this sister was a positive role model for what a family and a mother should be. She also explained how her non-Native foster parents made her feel special, and she still loves them, but the mother never accepted her. She later specified that it was her foster dad who made her feel special, and she did not accept her foster mom. "I don't know anything about motherhood because my mom was never around, and I was always passed on to aunties, sisters, back and forth." Several times she made statements of how her mom made her life hard for her, and how she didn't like being with her mother.

In response to, "Do you think that you should have a special feeling when you're a mom or you're a child?" Anne stated, "You need to... you need to let them know... your baby know that you're there for her... for her or him, when they need you. And that's what I want to do. And that's what I'll do." However, Anne also talked about her three year-old daughter who is being cared for by her auntie. In a sense, her own daughter is following in the same pattern as herself as a child, by being cared for by others. She wants to 'be there' for her child but in

actuality she is not. What is there to guarantee that the child of her current pregnancy will remain in her care as well? So in a sense she has brought a child in this world to love her and for her to love, but that could be as far as it will go; she may not be able to fully carry out the mother/child relationship in the way that she hopes, if this second child also becomes cared for by another. "I am not an alcoholic," Anne states, "and I'm going to let her [her three year-old daughter who lives with her aunt] know that I'm here for her if she wanted to come and visit or I never turn her away. And this is just temporary, and I want to take... get her back." At the same time she talks about her confusion and how difficult it is to not be caring for her three year-old daughter at this time.

Barb's childhood experience was one of happiness even though her mother did not raise her. "I'm very happy that she [her grandmother] raised me, because I often wondered where I would be if she didn't raise me. Because she gave me a good home, and I knew she'd always be there, she wasn't going to be taking off, or anything like that." She further explained that her siblings, who were raised in her mother's home, had hard lives. "Oh, my mother [her grandmother who raised her] meant a lot to me. She gave me everything I needed, in every possible way."

Deb also pointed out the unhappiness that she experienced as a child and how she did not want to carry out this pattern with her children. "...[I] didn't like the way we were brought up. I mean the way she treated us [herself as the second oldest, and her siblings] when she was drinking, but it's different now." She reflected about how demanding her mother would be when she was drinking, to have the children clean and make the mother something to eat at 3 or 4 am. "It [the drinking] makes the child feel ugly. Makes them [the children] feel they can do anything they want because their parents are drinking." She said that the children would be nice when the parents were sober, and bad when they were drinking-- have friends over, talk all night or go out all night. In response to, "So, it [the drinking] doesn't teach them [the children] to respect themselves?" "No,

like when my parents... Mom used to drink ... and I started to follow in her footsteps, like at a young age, trying to drink and then you know on purpose I'd try to get myself pregnant so I can have my own and live on my own, you know? So I can love and care for a child my way, you know? But it [getting pregnant] didn't... it didn't happen."

Deb also went on to explain what she believed a mother should provide for her child, "...to comfort them, love them, give them attention, be there for them, be involved with their schooling [as her parents weren't]." She also stated that a mother was "... supposed to treat [her daughter] with love and respect... I mean to not like put negative thoughts in our heads." She gave an example of this, of how her mother kept some personal things that she had said confidential, and how good that made her feel.

She also talked about her frustration in her current situation, and how she yelled at her son. Her boyfriend did not support them very well either emotionally or financially. She seemed frustrated and I could tell that she didn't want it to be this way.

In Ella's life she explained how her grandfather tried to compensate for the lack of attention from her mother.

Well, she [her mother] just left me with my grandfather, and she didn't come back until I was three, and then she had my sister. And then she left with my sister again, and I was left with my grandfather, so I don't want to do that. ...My grandfather kept me until I was about five or six years old, and then when I came in with just my mom, here in Saskatoon, she was pretty rough, she was drinking lots and she was a caring mother, took care of me. Its just she was drinking and going out lots, so I really didn't spend a lot of time with my mom as a child.



When responding to how it made her feel, Ella stated,

Not any less loved, because my grandfather, and I had a family... my cousins, and my uncle and my aunt up north. I don't really think... like she made up for it, she doesn't drink any more it's just... my grandfather showed me lots of love when I was a child, so I don't know. I wished she was there, I wish she'd raised me like she really did take that time to raise me, but what she did, I guess, it was her life [chuckles]. If she didn't come here, I wouldn't have my brothers and sisters so.... I'd like to be able to raise them [her own children] and be able to bond with them. I don't want to leave my children with someone. I want to raise them myself.

Fran also expressed her desire to be a different kind of mother than her own mother, in that she wanted to always be there for her children. She stated, "[A mother should] look after the kids... their personal hygiene, and stuff like that, and feeding them, always be there for them... like when they get into trouble and they're having problems and...I don't know... just how I grew up, and help them out." Later she explains how she was unable to maintain closeness with her mother due to family circumstances. "My mother and I were never really close. There were a lot of children that she looked after beside her own children. She was taking care of my auntie's children. She had foster children too. She never had time for us. She had to look after kids, cook, clean up the house. She didn't have time to, like, spend with me." Fran stated that she did not feel that her mother was always there for her, but the times that she did feel close with her mother was when they went camping and her mother would teach her and allow her to help her out.

Fran's expressions of her feelings when relatives would leave their children at her place, gave me further indications of what she felt was important in childrearing. "I see a lot of my cousins leaving their kids and like it just hurts me

to see them... the kids go through that... [they'd get left behind]... and they'd cry so much for their mothers, like I'm not.. I can't sometimes take part in looking after their kids, but like now I can't... I can't look after the kids." She explained how she used to take care of her relatives kids [for free] but now that she has her own she didn't want to do this as much. She felt that mothers should be more responsible for their kids, and should try to pay someone to look after them.

### **Relationship with their partner**

When I asked the women to describe what a healthy family meant to them, Anne stated, "I just want... I want to be a family, like... you know, like mother, father, kids, no problems, like drinking problems or drug problems, anything like that." She described her sister's family, which was like what she hoped for. She also confirmed that she wants this dream with her current boyfriend, who she said has plans to go to school, but is currently not working, and whom she supports (financially is my assumption). She also said that she is scared of his drinking, he disapproved of her seeing a counsellor, and that he is short-tempered but he can, "control it, not like my past boyfriend." Her description of the pattern with her old boyfriend, was that he made her feel 'ugly' and made her believe that she was no good. "He kept me isolated, and used to just get mad over little things, and I used to listen to him when he said I was no good, I wasn't good and I was a nobody." She goes on to add, "But I'm happy now. Happy. So different." I could see how this statement conflicted with a lot of negative things she had said about her current boyfriend, but her perception was that he was an improvement from the past boyfriend.

Barb seemed to have a more realistic view of her relationship and her responsibilities towards her unborn baby and her boyfriend. When I asked her, "What is it like to be a woman?" she responded by saying,

There's a lot of responsibility, more than there is for a guy I think, like having to clean up and cook. I'm going to be totally

responsible for myself and my baby. Like, I wouldn't want to... like I'm looking at way later, you know like if me and Bob were to ever break up and you know, I'd be totally responsible for my baby. I have a couple of friends that I'm really close with, and like we have a bond, and like just between friends I guess. I don't know if I'd have that friendship with them if I was a man. But with a lot of my friends, they are a lot of single moms, that are my friends, and ya, they have taken the responsibility all to themselves.

Barb described how she thought she'd be a single mother because her biological mother was. "I always thought like, I would be a single mom myself, ...and maybe because she [her mother] was, I always assumed I would be. But I'm happy that I have Bob and like we're going to be doing it together. I'm guess I'm just looking at things realistically. Like, you know, who knows if me and Bob are going to be together, or get married, or whatever, eh?"

Deb explains how her thought pattern was at age fourteen when she was trying to get pregnant, and how she is glad that she didn't as her children would all be from different fathers. She further states, "I was hoping that the person I was going with at the time would stay with me but obviously that didn't happen." When talking about her current pregnancy in the hopes that it will bring her and her boyfriend closer together, she stated that it was, "Not just for my sake but I wanted to have a family, like... a long-term relationship, and have a family for my kids... and have my kids like just one perfect family." She stated her definition of a 'perfect family' as having "...family outings, where everyone in the family is involved with each other's lives...caring, showing concern." She clarified this by saying that her family of origin cared for each other but they didn't share anything with each other.

Though Deb envisions this dream with her current boyfriend, there seems to be little hope that she will get what she wants with him. He has already stated

that he is not ready to get married, and he lives most of the time with his mother. His family and friends tend to be quite demanding with his time as well, and this takes away from her time with him. For example, he will drop everything with her to attend to the needs of one of his cousins. He also hangs around 'shady' people, one of whom threatened Deb with a gun and knocked her down. She said that he sells drugs and hangs around with drug dealers. In the same breath, she said that he wants to start up his own business, a legal one, and is currently working towards this. She has also expressed her frustration at his lack of support for herself and their son. Sometimes he will do things such as say he is going to the store and not come back for a week. She says that she gets frustrated and hurt and angry at times, and wonders why she stays with him, but she still loves him and has hopes with him.

Ella has a very interesting arrangement with her boyfriend, who is not the father of her two year-old. He does not live with them but comes over on a regular basis to visit and to take out her two year-old. She says that they call each other almost every day and that they do care for each other, they just can't live with each other or they will start fighting. I do not know what the fights are about. She considers him to be supportive of her and her child, but she also has misgivings about the amount of work that lies ahead for herself with a newborn and a toddler. She said that he really has no idea of what she will have to go through in caring for them. She and her child live alone in an apartment.

Fran's current boyfriend who is not the father of her other two children, 'stays with her' sometimes. Right now she is glad that he is with her and she feels supported by him. He is with her until she has her baby and there is no guarantee where he will be after the birth. Fran lives in a newly renovated low-income duplex in a quiet neighbourhood, with her children.

### 4.3.3 Personal Growth and Ambition

In existing studies of high-risk pregnant women, there is very little discussion of their personal goals in life. Perhaps it is expected or assumed that women living in these conditions are too preoccupied with a survival or crisis mode to think of much else. This may be true, but personally I still feel that is important to acknowledge and nurture each other's personal aspirations and dreams, in the hope that they will someday be realized. Sometimes a person has to envision the possibilities before they can move ahead.

When I asked Anne if she saw positive things ahead for herself, she responded,

Ya, I'm learning to be confident in myself, and a lot of things like that, to support myself and make myself feel good. And I was slowly doing good, and then it felt like he... this guy I'm with right now, he brought me down a lot, but I'm fighting hard for myself, and I'm not going to let him bring me down like the... first one did.

When I asked her what she will do to stop the abuse from her current boyfriend, she said,

Not listen to him when he's criticizing me and do what I want to do, and encourage myself. That's it. My first one was very mean. He let me... he brought me down so low I couldn't... I didn't want to do anything with my life. I talked to a counsellor and that's very supportive for me. I started seeing one after he went to jail, that guy I was staying with. And ever since then I was learning a lot, and I was... I felt better about myself. She [the counselor] made me feel good, and I liked that. Like, I can count on her to talk to. But sometimes I have a hard time contacting her and meeting her, because this one [her current

boyfriend] doesn't want me talking to anybody, but I just... I don't listen to him, I just say, we're just going to talk.

Anne described her support systems, her cousins and her ability to reach out for help. "I can't count on anybody but myself. I have no one to count on. But I'll... like I always find someone to count on, or when I need somebody, I'll find somebody. There's always somebody for me." I especially noted this to be true when she called me from the hospital after the birth of her baby, for a ride home. Her boyfriend was present during the birth but had not been in to visit them since that time. He was at home waiting for her to arrive. I handed the baby to him at the front door of the apartment complex when I dropped them off.

Anne was trying to associate herself with those who will support her, but it was difficult to tell how well she was doing in this. In response to, "Do you see any positive role models of women?" she said, "Ya, I do. I don't know, it's... it's really hard for me to think like that, because everything is so negative for me. Nothing ever positive, nobody ever taught me about being positive. It's always negative. And it's hard, but I try." Though she wants to improve herself, she is also with a man who is insecure, and unsupportive about her doing this. There was a point as well that I felt a sense of control from him when I would phone her. Because of this, at one point I decided to meet with her away from her home environment and she seemed quite relieved when I asked her if she wanted to go out. After the baby was born I noticed that he seemed more relaxed with me. He handed me the baby during one visit, and he also changed my flat tire outside their apartment complex.

Barb had some pretty set ideas on what she wants in life when I questioned her using the picture probe. Her goals are to take care of her baby, go back to school, and to raise the baby with its father. At one point I even thought of eliminating her from the study, because she did not seem to be as 'high-risk' as the others. Deb has a dream to help others, "to go back to school and be in a helping profession." Currently Deb is in school and is planning to stay there after her

baby is born. She talked about seeing women out on the streets and in bus shelters with their babies, and wished she had a car so that she could help them out. She seemed to have a caring nature. She also talked about discussing God with her in-laws, and how she enjoyed doing this and going to church with them. To me this shows that she has a desire for spiritual growth and personal development. Ella and Fran seemed to be focused on their role as mothers.

#### **4.4 Summary**

In a way, one could take these findings and use them to validate what has been discussed in the literature. After all, all of these women (except Barb to some degree) do manifest the 'profile' of high-risk pregnant Aboriginal women. It was my choice however, to focus on the 'other side of the coin.' I could have looked at their answers, such as them being happy about their pregnancies, and said, "They were living in a state of fantasy" or "Look at their living situation, how could they truly be happy about their pregnancy?" I suppose I could still say this and bring out my findings to reflect that view, but I choose not to. As Lord and Hutchinson state, in the process of self-empowerment, "participants often alluded to the influence of others in helping them to capture or recapture their dreams."<sup>184</sup> Sometimes, hopes and dreams are all we have and all it may take for some is for others to assist in validating that for us.

## **CHAPTER 5: DISCUSSION OF THE FINDINGS AND SUGGESTIONS**

### **5.1 Introduction**

This chapter will bring everything together into a conclusion. Hopefully it will make sense and offer the reader some new insight, as well as some practical suggestions for program development.

#### **Limitations**

Limitations have been stated throughout the methodology. My personal assumptions and beliefs required rigorous identification and restraint. The sample was small and purposeful. My interviewing techniques required skills that I was not used to. Time was the major limitation. In light of the very personal information that I had to obtain, the limited time factor may have affected participants' ability to share their true feelings. As I mentioned, I felt like I was beginning to feel comfortable with the participants by my last interview with them. Not only was I becoming more comfortable with my interviewing techniques, but I also think they would have opened up to me more if I had the time to interview them further.

#### **Phenomenological approach**

The phenomenological approach was useful and appropriate in gaining further understandings in this area of research, though I did not consider this study to be truly phenomenological. This was particularly evident when I had to continually reflect on my preconceived ideas and knowledge of the subject of Aboriginal high-risk pregnant women. Did my own thoughts and experiences cause me to set up the questions and methodology of this research? At times I wondered if it was an ethnographic or phenomenological study. I believed that the research questions developed after I began the study, and that it truly was an exploration into the unknown. I hoped I was able to make a distinction between



what 'appeared to be important and what really was'. I do believe however, that the information that I gleaned gave additional and significant insight into the perceptions of these women.

## **5.2 The Picture: From Both Eyes of the Researcher**

After much reflection, there are two different ways of 'seeing' the overall problem of Aboriginal maternal health, and seeing the overall solutions to the problem. From this research I see two worldviews that are struggling to coexist: the Aboriginal worldview and non-Aboriginal or Western worldview. Not only are they struggling to coexist in the world of health care, but they are also struggling within myself as the researcher. This research has been an extension of my own personal development and self-identity as an Indian woman who has ties with both the traditional Native world and contemporary Western world. This research contains my heart, the 'third' eye, and this will be evident as I discuss the findings. My heart extends out to the women in my study and their families. My heart cannot help but be touched by this research, the people, because they are a part of me.

From one eye I see a bleak picture showing the poor health conditions of Aboriginal women and children in Canada. We [I refer to 'them' as 'we' since I am also part of this population group] are seen as impoverished, disempowered, uneducated, and unhealthy. We are victims-- of society, of our history, of our dysfunctional families, and of our abusive partners. Our children, who have been raised in chaotic conditions, face a bleak future. What can possibly save us-- education, knowledge, money, better housing, healthy food, healthy relationships? We 'need help'. Equal opportunity, better education, counseling, further understanding, cultural recognition, and respect are some of the things that I have heard from the dominant society that we 'need'. We also 'need' to be heard. Our voices are too timid, too quiet. After all, I have heard people say that we have 'interesting views', and that our culture is 'interesting'. People think our history is

sad and we can't be blamed for our 'conditions'. I see and hear the helping profession try to help the Aboriginals work themselves out of this bleak picture into the opportunities that every Canadian should enjoy.

One part of this great expanse of Canadian opportunity is the area of health. But why aren't we as healthy as other Canadians? Why are our morbidity and mortality rates still higher than the rest of Canada? Why do Aboriginal women still have such unhealthy lives? And why do our children continue to suffer? We have a good health care system and every person is provided with the opportunity to be educated. There must be some way to bring about sustained healthy behavioural changes in Aboriginal women, and thus reduce the rates of physical and congenital health problems in our offspring.

Over the years, Canadian health care providers have sought to educate and support pregnant Aboriginal women in a variety of ways and settings. Still, so many Aboriginal women continue to carry out behaviours which put their children 'at risk'. This continues to be a frustration for health care providers. It is hard to not put blame on the victim. It is hard to not get frustrated with the women who 'bring the trouble onto themselves'. It is easy to get burnt out as a health care provider. It is easy to become apathetic. The non-Aboriginal health care provider does not see the answer. He or she has tried everything they know to 'help' these women. Some are successful in their ambitions, as some women do change their behaviours, but there are still so many who don't.

I see the frustration so clearly, even though non-Native health care providers try hard not to show it. At times this seems to cause them to become even more zealous in their determination to do their jobs. Always looking for an answer to solve the mystery. Incorporate cultural aspects into the program. Learn about Native history. Take a Native Studies class. Go to a Native health conference. Talk to Native health care providers. Hire Native health care providers into the program. Try to be more empathetic. Try to understand the

view of the Indian. Try to live in their shoes. Advocate for the Indian, speak for the Indian, even when Indians are present in the same room.

From my other eye I see a world that is hidden from the western world. It is a world that thrives in Aboriginal culture and tradition. It is a world of healing and a world of teaching, and it offers hope to our People. Self-pity is not prevalent here. I wonder why that is? Others seem so sorry for us. The elders seem so proud and wise. We learn to listen and we are taught how to pray. The Creator opens up our hearts and things start to make sense. We see our lives changing, and good things come our way.

The teachers and the healers are strong and patient. They are tolerant of our ignorance. They are loving and humble. They are available, always there for the People whenever they are needed. They have a hard life. I would not want to be an elder. Their life is a sacrifice to the People, their life is not their own.

'Bring the People to learn about Indian psychology,' I recently heard one elder tell a non-Native psychologist who was treating a Native family. But you will find no offices, no policies, and no paperwork here. I cannot tell you what you would find as it would not be proper to write it on paper, but I can tell you about some of the things that we would learn.

We would learn about who we are, and where we come from. We would learn who our family is. We do not hear much about what is heard in a Native Studies class. Some of that is in there, but very little. The books are just a starting point for some, a form of knowledge that sits on the surface. In this world, we learn about things that go far deeper-- a deeper form of history that extends deep into the Earth and goes far back in time.

We would also learn about who we are as women and what it means to respect ourselves. We learn what it means to bring new life into this world. We learn the traditional ways of parenting. We learn about the bond that we used to

have with our mothers, sisters, aunts and grandmothers, and how we can start that again.

From the teachings and involvement in the ceremonies we become re-connected, and we start to heal. Attitudes about our lifestyles start to change, and we find direction and strength to lead a better life. We begin to see our own worth and the worth of the children that we bring into this world. We are no longer powerless. We have gained the knowledge and wisdom of the ages. We become strong.

These are the two worlds that I have seen in my 38 years. I am a health professional, and I am a client, and I am still learning. I have higher education in the Western world and a lower education in my culture. I don't see everything clearly, but I do know that there is a problem when these two worlds that I have described try to 'get along'.

So how could these two worlds meet in a way that would bring effective change in the overall picture of Aboriginal maternal health, and how does this fit in with the perspectives that I have gained from this research?

### **5.3 Discussion of Themes**

Each of the three themes has one thing in common, and that is the desire of the women to improve their lives. They have expressed their desire to improve their parenting, their relationships, and themselves. The degree and the sincerity of this ambition was not captured in the data. However, the desire still remains, whether it is weak or strong. One certainty remains, however, and that is that none of the women, except perhaps Barb, has manifested these desires in her life. The question then that could be asked, is, "What would motivate or cause these women to move towards making positive sustained behavioural changes in their lives and thus reduce the prevalence of poor pregnancy outcomes?" They all have dreams, and seem to hope for many of the same things as what health

professionals would hope for them such as healthy families and relationships, but they are obviously 'stuck'.

One might think that these women could be apathetic as this is one term that I have seen used to describe them in the literature review. The term apathy means "lack of interest" and according to the Oxford Dictionary of Current English, another word to describe apathy would be 'indifference.'<sup>185</sup> Synonyms of indifference are "unconcern, nonchalance, coldness, insensitivity, disregard, callousness, neutrality, disdain."<sup>186</sup> These words simply do not describe these women. I also asked the elders about this and they agreed that these women are not this way. They care about themselves and their children and others.

So I tried to think of another word that would help to describe them. I looked up the term 'motivate' to see how it could apply to these women. Synonyms of the word 'motivate' are "impel, inspire, hope, stimulate, incite, propel, spur, move, induce, prompt and arouse."<sup>187</sup> The definition of motivate is "to cause (a person) to act in a particular way and to stimulate the interest of (a person in an activity)."<sup>188</sup> Or as Zimbardo puts it, "Motivation is a general term for the process of initiating, directing and sustaining physical or psychological activities." It is also an intervening variable. It can be induced by physiological and/or psychological variables and may lead to physiological responses as well as conscious or non-conscious psychological ones."<sup>189</sup> The elders have said that frequently these women are used to rejection over the course of their lives and many have developed an 'oh well' attitude towards life—which, in my opinion, is not apathy, but more like lack of motivation or lack of movement towards behaviour which is positive.

It is not my purpose in this study to come up with any sort of clinical diagnosis of the participants' state of mental health as that is not my field of study. Even understanding the whole concept of motivation and the many other variables which affect human behaviours are too hard for me to even begin to comprehend. However, as Horn suggested, I believe that more needs to be understood about the

social, cultural and motivational factors of Native American Indian women during pregnancy.<sup>190</sup>

### **5.3.1 Negative Motivational Variables**

Perhaps as health care providers, we know more about the negative variables or factors in these women's lives which work against or cause 'immobilization' towards achieving positive behavioural change. Variables such as fear of abandonment and violence from their partners, lack of good support systems, poor coping methods, feelings of powerlessness, issues from their childhood upbringings, financial problems, tiredness, unsettled living conditions, and other effects of poverty are some of the things that have been evident in the lives of the women in this study. All of these factors have been clearly depicted in research studies of behaviours of high-risk pregnant women and in their prenatal care utilization patterns.

Aboriginal elders had some insight to offer about these women as well. Though the women all seem to have a lot of love to give their children, the stresses that they were going through in child rearing due to poverty and lack of support from the fathers are clearly evident. According to one elder, the lives of these women are carried on from childhood, and in a sense they are still like their mothers, even though they do not want to be. All of the women either lived with or were involved with men who were not employed and whose support was questionable. Three of the women had children from different fathers, which said a lot when the next father was as unsupportive as the previous one. One elder who works with young women like these says that frequently they support the drug habits of their partners. I knew this to be true in one case, because Deb talked about her partners' drug dealing. Anne also admitted to smoking marijuana during the beginning of her pregnancy, and I assume that her boyfriend carries on with this behaviour.

Elders also said that these women seem to have very little family support, especially since they live in the city. So they could be isolated in one sense, even though their HMHB risk profile says they are not. Elders also state that frequently the women know very little about their culture, and that sometimes there is a misconception by social and health care workers that they do not *want* to know. They also know very little about prenatal care and breastfeeding.

Since maternal health promotion programs are primarily delivered by non-Native health professionals, the way in which they have been delivered has been based upon the Western societal way of thinking. People who teach with this worldview tend to stress cognitive abilities and powers of reasoning in their efforts to educate and support their clientele.<sup>191</sup> For instance, the high-risk maternity client is taught the effects of substance usage on the fetus. The purpose of good nutrition is also emphasized, as well as the importance of attending regular doctors checkups during pregnancy. Support is given in areas such as home visits, assistance to get to medical appointments, referrals to counselors, nutritionists and advocacy-type support. Most of this support is given in the form of offering information, on such issues as housing, education, and mental health support. I did not ask the participants for any feedback regarding the care from the HMHB POP and they did not offer any concern or insight into this matter. All I can say is that no complaints were actually made about the program, but no compliments were made either. Since it is not my purpose to evaluate the program, I will not say that the above way of delivering education and support is good nor bad for Aboriginal women— it is simply one way of delivering the service.

One factor in program delivery that I feel is pertinent, though, is the tendency of health care providers to focus more on the unborn child than on the mother, her partner and her family.<sup>192</sup> This type of ‘support’ could cause the high-risk mother to feel even worse or guilty about her situation and could further alienate her from the health care provider and the system in general. As one of the participants of this study mentioned, “sometimes the right questions are not

asked,” [about her situation], as she was enthusiastically sharing her feelings about her life with me. It seemed as if all of the women wanted to share what was on their minds during this time of their lives.

It is important to note that participants actually said very little about their perceptions of pregnancy itself, but rather they discussed other areas of concern, which in my mind could have direct relevance towards the healthy outcome of the baby. For instance, if they are preoccupied with being abandoned or being abused by their boyfriends, then that has to be acknowledged so that the mother can be offered the support to prevent neglecting herself and compromising the health of her baby at that time. Furthermore, if the pregnant woman feels worse or guilty about her behaviours as a result of the perceived treatment she is receiving from her health care provider, it is highly unlikely that her behaviours will change. As Elbourne says we need to give an equal regard for the daily concerns of the pregnant woman as an integral component of maternal care, in the hope that they will take better care of themselves and also focus on their unborn baby’s needs.<sup>193</sup>

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### 5.3.2 Positive Motivational Variables

Researchers seem to know little about the variables that would induce positive behavioural changes in high-risk pregnant women. Two studies stated that support, assistance of loved ones, and the encouragement and advice of others are strong motivational factors to seeking prenatal care.<sup>195 196</sup> Other ethnographic studies have indicated that birth outcomes of First Nations women could possibly become improved when Native spirituality, cultural identity, pride in motherhood and womenhood, family closeness and support, and the role of the father are strengthened.<sup>197 198 199</sup>

This study has revealed some of the perceptions about what is meaningful to these women during this time in their life journey. But what do they need in their lives that would motivate them to carry out their hopes and dreams? What



motivates a woman to 'move on' in her life? For some the pain that they go through is enough to motivate them to do something about it.<sup>200</sup> Elders have commented that this is when these women will usually come to them, when they are in crisis. This is usually the time that the elders are able to direct them to support systems and traditional ceremonies for personal healing and teachings.

For other women, motivation could be the "glimmer of hope and of new possibilities provided by role models."<sup>201</sup> Would cultural teachings, nurturing, role modeling and support by other women who genuinely care for them, help to inspire them? One observation I had when I visited these women, was how they 'lit up' when they met me at the door. They welcomed my visits. This could have been because I showed them and their family that I cared. They seemed to enjoy the attention that I gave them and their children. Some of them phoned me at home and asked questions about their health, and one even wanted me to talk with her sister. They also seemed this way with the Aboriginal outreach worker, whose clients described her as 'grandmother' to many of their children. Elders say that it is good that these women are involved in the health outreach programs, but that they also need the nurturing, the role modeling, and the cultural teachings. "As workers we must be mother, sister, auntie to these women." "Our culture is different from the professional White People, we get involved, take them shopping, and go to them." "Our children are on loan to us all," says one elder, "they should be our first priority." "These women need to know the sacredness of being a woman."

The Indian way of coming to truth involves looking at the spiritual, physical, emotional and mental aspects of human beings. Seeking knowledge and coming to truth necessitates studying or looking at cycles, relationships and connections between things.<sup>202</sup> Schorr supported this in her description of successful programs, where she stated that programs should, "see the child [in this case the unborn child] in the context of the family, and the family in the context of its surroundings."<sup>203</sup> Aboriginal teachers and elders 'see' the same problems and

issues occurring in these women's lives but 'how' their problems would be dealt with would be different, but, I believe, complementary to the non-Native or Western way, as depicted in the examples in Table 5.1

**Table 5.1** Compatibility of Western and Aboriginal educative and supportive roles.

WESTERN	ABORIGINAL
Educational teachings to mother: such as nutrition, effects of substance usage on the fetus.	Traditional educational teachings to the pregnant women and her family: such as what foods to eat, as well as when and why. The spiritual aspects of pregnancy, sacredness of the child.
Support to the mother: such as home visits by health professionals, rides to the doctor, advocacy.	Support to mother and family by way of role modeling, nurturing and love. Advocacy, visits, prayer.

I do feel that further study in understanding the area of positive motivational factors or the process of how to work towards empowerment of high-risk pregnant Aboriginal women would assist health professionals in their quest to reduce poor pregnancy outcomes.

#### **5.4 Five Suggestions Towards Empowerment of High Risk Pregnant Aboriginal Women in Health Promotion Programs**

It is my opinion that the Aboriginal clientele of health promotion programs, such as the HMHB POP, would benefit more if the programs capitalized more on the desires of the women, along with the direction of the Aboriginal community and elders. Though my participants did not actually state that they wanted traditional teachings, they did want to achieve positive outcomes in their lives that the elders believed could have come about with the help of cultural practices and teachings. As the elders have stated, sometimes these women themselves know very little about their culture because they were not

taught or raised that way. They are unfamiliar and possibly afraid of what to expect, due to an upbringing that may have instilled fear of this aspect of their heritage.

The question is, how do health promotion programs provide for this need? How can health promotion programs work with this population group to successfully achieve their common interests? I have summarized five suggestions based on the discussion of the findings of this study, and my personal experiences.

I would suggest that the first step would be a true acknowledgement of the inherent differences between the Aboriginal clientele or community, and the non-Native health care providers. And I think it's important to not be 'afraid' to do this. I think that there is a fear that it might promote segregation or discrimination of some kind, but I feel that the opposite is true. The word 'community' implies people who share common interests, a common history, a common culture, or a common identity, all of whom may or may not be enclosed by a common geographical boundary.<sup>204</sup> Though many of the Aboriginal clientele of the HMHB POP are not residing in their home communities, I believe there still remain commonalities of interests that constitute them as an urban-based Aboriginal community. In other words, though they live here they are not necessarily assimilated into the dominant culture. They may, in fact, still maintain strong ties with their own history, identity and culture. This has direct implications towards development of this community. The literal meaning of 'development' has its roots in the process of growth in the natural world,<sup>205</sup> but it can also imply change and growth of individuals, families, cultures, organizations, institution, and communities. Development also implies improvement, which in the view of certain cultures has been primarily associated with industrialization, modernization, and economic transformation.<sup>206</sup> Other cultures, such as in the Aboriginal worldview, may see development in a holistic perspective, such as the development of our mental, emotional, physical and spiritual dimensions.<sup>207</sup> The improvement in people's quality of life is implicit in community development,

however, exactly what this means must reflect the individual community-- its diversity of human beings, their vision and the complexities of their life situations.<sup>208</sup>

Secondly, I would like to see an acknowledgement that non-Native health care providers and programs are limited in their knowledge of the clients' worldview and *always will be*. Admitting this would be totally acceptable to the Aboriginal community and it would be a relief, I'm sure, to those who try so hard to understand a worldview that is not their own. Admission of this places value on the knowledge of the Aboriginal community and alternative systems of knowledge production, such as traditional health practices.<sup>209</sup> It is acceptable for health care providers to try to gain cross-cultural understanding; however, the information provided by Native studies classes, workshops, and conferences will never sufficiently teach the Aboriginal worldview. Learning about one's culture takes a lifetime of experience, and even Natives (like myself) who were not raised in their culture will take the rest of their lives to learn about their culture.

Thirdly, I would like to see non-Native health providers be comfortable with the idea of sharing power. "Health workers can all too easily be persuaded that their own sphere is the most important one in people's lives and the only arena for participation and control of services."<sup>210</sup> Caution must be taken to make sure that the health professional's role of advocate is truly one of partnership and an enabler of community self-empowerment.<sup>211</sup> Consider the need to advance beyond developmental casework, to achieve better results by moving further up the community development continuum with the possibility of working towards development of mutual support with the Aboriginal community.<sup>212</sup>

A partnership with the Aboriginal community would enable the community to teach cultural aspects in the way that is most appropriate to them. The common response that I have received from elders when discussing my research was that 'the teachings are there.' The teachings are available and are currently being accessed by Aboriginal women in Saskatoon. Why not approach

the urban Native community and see if they would be interested in setting up the cultural component of the health promotion program? They can assess what is needed, how it should be delivered, and what they would like to see accomplished. It is true that the HMHB POP carried out an initial consultation with the Aboriginal community in setting up the program, but that was quite a while ago. Community consultation and communication needs to continue and programs need to evolve over time.

Fourthly, I would like to see a realization of the limitations of the common practice of health promotion programs to try to achieve risk reduction through incorporation of cultural aspects in social marketing, and education.<sup>213 214</sup> This continues to be a predominant perception of health promotion among decision-makers and is shared to some extent by key informants.<sup>215</sup> In my opinion, only trying to achieve results this way, could be seen as a means of social and economic control over the group that it wishes to serve. Incorporation of cultural knowledge and practices into a health promotion program, in itself is not necessarily a form of community empowerment.<sup>216</sup> It may generate some positive results, but I doubt if this method will be truly effective in changing health behaviours of the clientele in the long run.

And lastly, realize that making changes together is a political process, that the skills and scope of this process is a major venture, and it will be a difficult process.<sup>217</sup> Advocate with the Aboriginal community, do not speak for us.<sup>218</sup>

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**APPENDICES**

## APPENDIX A

### HEALTHY MOTHER HEALTHY BABY

#### *Prenatal Risk Identification*

<b>DEFINITION OF RISK: An increased probability of adverse outcomes.<sup>1</sup></b>
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**Note:** A risk identification tool is a guide only and should be combined with the personal experience, knowledge and intuition of the professional.<sup>2</sup>

#### **PRENATAL RISK CATEGORIES**

**Low Risk Pregnancy** - *A pregnancy in which minimal intervention is needed to prevent the pregnancy from becoming high-risk.*

**Medium Risk Pregnancy** - *A pregnancy in which, given the current and past circumstances of the client, the potential exists for the pregnancy to become high-risk.*

**High Risk Pregnancy**- *A pregnancy in which the mother and/or the fetus has an increased probability of maternal and morbidity prenatally and intranatally.<sup>3</sup>*

#### **PRENATAL RISK FACTORS**

1. **POOR OUTCOME OF PREGNANCY:**
  - low birth weight infants
  - abortion – spontaneous or elective
  - stillbirth
  - neonatal or infant death (ie. SIDS)
  - previous high-risk infant
  - previous child with anomaly or disorder
  -
2. **ILLNESS OR CONDITION THAT MAY AFFECT THE PREGNANCY IF REGULAR MEDICAL CARE IS NOT PROVIDED:**
  - pernicious vomiting
  - diabetes
  - hypertension
  - urinary tract infections
  - STD's
3. **LOW OR HIGH PRE-PREGNANCY WEIGHT GAIN (BMI).**
4. **RATE OF WEIGHT GAIN:**
  - Inadequate weight gain in second or third trimester:
  - Rapid weight gain in second or third trimester
5. **INADEQUATE NUTRITION**
  - consistently less than the minimum recommended servings in 1 or more food groups
  - eating disorders
6. **MULTIPLE PREGNANCY**
  - usually results in premature birth

<sup>1</sup> Source: Pregnancy Outreach Handbook, B.C. Ministry of Health, March 1993

<sup>2</sup> Ibid

<sup>3</sup> Ibid

7. **BIRTH INTERVAL**
  - less than 2 years between births results in a high incidence of fetal growth retardation and prematurity.
8. **MULTIPARITY**
  - higher risk of morbidity occurs at the first pregnancy and at the fifth pregnancy or more.
9. **AGE AT TIME OF DELIVERY**
  - pregnant women 17 years of age and younger risk low birth weight infants,
  - pregnant women 36 years of age and older risk infants with chromosomal abnormalities
10. **ALCOHOL USE**
11. **SMOKING (CIGARETTES)**
12. **DRUGS-** over the counter, prescription , street drugs.
13. **FINANCIAL PROBLEMS**
14. **RELATIONSHIP PROBLEMS**
  - unstable, lacking support, abusive
15. **SINGLE PARENTHOOD**
16. **MENTAL HEALTH PROBLEMS**
  - low self-esteem
  - poor coping skills
  - depression
  - stress
  - difficulty accepting pregnancy
  - mental disability
  - neuroses, psychoses
17. **INADEQUATE HOUSING**
18. **DELAYED ACCESS TO PRENATAL CARE AND/OR LACK OF REGULAR FOLLOW-UP VISITS TO M.D.**
19. **ISOLATION**
  - ethnic
  - language
  - social
  - geographic
20. **LIMITED LEARNING ABILITY/ILLITERACY**

## APPENDIX B

### PARTICIPANTS PRENATAL RISK FACTORS SUMMARY FROM HMHB

<b>PRENATAL RISK FACTORS</b>	<b>ANNE</b>	<b>BARB</b>	<b>DEB</b>	<b>ELLA</b>	<b>FRAN</b>
<b>Previous Poor outcome pregnanc(ies)</b>	YES	YES	NO	NO	YES
<b>Illness or condition(s) needing medical treatment</b>	NO	YES	YES	NO	YES
<b>Low or high pre-pregnancy weight</b>	LOW	HIGH	NO	LOW	LOW
<b>Weight gain during pregnancy: Adequate/Excess</b>	ADEQUATE	EXCESS	EXCESS	ADEQ.	ADEQ.
<b>Nutrition: Poor, Eating disorder</b>	ADEQUATE	POOR	POOR	ADEQ.	POOR
<b>Multiple Pregnancy</b>	NO	NO	NO	NO	NO
<b>Less than 2yr. Birth interval</b>	NO	NO	NO	NO	NO
<b>Parity: Primip, Multipara</b>	N/A	N/A	N/A	N/A	N/A
<b>Age at Delivery</b>	22	24	21	22	25
<b>Alcohol Use During Pregnancy</b>	YES	NO	YES	NO	NO
<b>Smoking During Pregnancy</b>	YES	YES	NO	YES	YES
<b>Drug Use During Pregnancy</b>	NO	NO	NO	NO	NO
<b>Financial Problems</b>	YES	NO	YES	YES	YES
<b>Relationship Problems</b>	YES	NO	YES	YES	YES
<b>Single Parent</b>	YES	NO	YES	YES	YES
<b>Number of Children &amp; Age(s)</b>	1 X 3yr	N/A	1 X 3yr	1X3yr	1X2yr, 1x4yr
<b>Mental Health Problems</b>	NO	NO	YES	NO	NO
<b>Inadequate Housing</b>	NO	NO	NO	NO	NO
<b>Delayed Access to Prenatal Care</b>	YES	NO	NO	NO	NO
<b>Isolated</b>	NO	NO	NO	NO	NO

## APPENDIX C

Using University of Saskatchewan Letterhead

### INFORMATION FOR PARTICIPANTS FORM

For the involvement in a study of the perceptions of high risk pregnant Aboriginal women.

#### INTRODUCTION

This research project is about looking at the stories and experiences of Aboriginal women's perceptions during pregnancy. The participants will come from the Healthy Mother Healthy Baby Program in Saskatoon.

#### RESEARCH PERSONNEL

This study is conducted through the Department of Community Health and Epidemiology at the University of Saskatchewan.

The researcher is Sue Wilson. I am an Aboriginal graduate student in this department, working on my Master's Degree in Science. This research is a part of my requirements to finish this degree. I am also a registered nurse and very dedicated to promoting the health and well-being of Aboriginal families. I am from the Mushkegowuk Territory in James Bay, Ontario. I am a single parent of four young children.

My research supervisor is Dr. K. Green, who is a member of the Department of Community Health and Epidemiology.

#### ORGANIZATION OF THE STUDY

- If you decide to take part in the study the researcher will meet with you 3 to 5 times.
- The first meeting will be short, the second meeting will be an interview lasting approximately one hour. The subsequent meetings will be shorter to validate things with you.
- The meetings will take place at your home or anywhere it is convenient or preferable for you.

#### POTENTIAL BENEFITS OF THE STUDY

- This particular kind of research is under-represented in the area of health. The voices of Aboriginal women need to be heard, for our selves and for our children. We have the answers to what we need in maternal health and the world should listen.



### RISKS OF THE STUDY

- There are no anticipated side effects of the study.
- It is possible that talking about the subject will bring up painful memories.
- You are free to change the subject whenever you wish or withdraw completely from the study.

### CONFIDENTIALITY

- Your name will not appear in any place in the study.
- Your personal history will be changed to protect you anonymity. You will be able to change the transcripts of the interviews where you see fit.
- Only myself and my supervisor will have access to the transcripts (not the Healthy Mother Healthy Baby program or anyone else).
- Every attempt will be made to ensure confidentiality.

***Protection of your identity, your dignity and your well-being is my first concern.***

### CONSENT

I will go over the consent form with you. The consent must be clearly understood by you and revisions can be made anytime during the research. The consent is there to protect you.

### VOLUNTARY PARTICIPATION

If you choose to participate in this research, it is purely voluntary. This means that the information that you give is given because you want to give it. You can withdraw at any time from the study.

## APPENDIX D

Using University of Saskatchewan Letterhead

### PARTICIPANT CONSENT FORM

For involvement in a study on urban Aboriginal women's perception of pregnancy.

I, \_\_\_\_\_, volunteer to take part in a study of urban Aboriginal women's perception of pregnancy.

I understand that:

- My taking part in the study is voluntary.
- I may withdraw from the study at any time.
- If I do withdraw, everything that I have contributed to taking part in this study will not have any effect on how I am treated during the Healthy Mother Healthy Baby program in any way.

The researcher, Sue Wilson, has gone over the study with me and I understand:

- My part in the study will include taped interviews which I can edit before she uses them in the study.
- I can see my part of the contribution to the study.
- The study is part of a Master's Degree thesis.

I understand that no one will be able to identify me in the study:

- My name will not be written in any part of the study.
- The only ones who will have access to the tapes and transcribed copies will be Sue Wilson and her supervisor Dr. Kathryn Green.

The above contents have been explained to me, and I understand them:

- I agree to allow the interviews to be taped.
- I agree to allow the researcher Sue Wilson, to have access to a summary of my high risk health factors.

I can contact the researcher Sue Wilson or her supervisor at the following phone numbers in Saskatoon:

Sue Wilson 373-4029 (home) or 966-7930 (university)

Dr. Green 966-7938 (Department of Community Health and Epidemiology, University of Saskatchewan).

DATE \_\_\_\_\_

SIGNED \_\_\_\_\_  
Participant

DATE \_\_\_\_\_

SIGNED \_\_\_\_\_  
Researcher

DATE \_\_\_\_\_

SIGNED \_\_\_\_\_  
Witness

**APPENDIX E**  
**INTERVIEW QUESTIONS**

**OVERALL QUESTION: WHAT ARE THE PERCEPTIONS OF PREGNANCY OF URBAN HIGH-RISK ABORIGINAL WOMEN DURING PREGNANCY?**

**FIVE OPENING QUESTIONS:**

1. What did motherhood mean to you as a child and adolescent?
2. What is it like to be a woman?
3. What was it like when you first realized you were pregnant?
4. How do you view your relationship with yourself and your unborn baby?
5. What is it like now that your baby is close to being born?

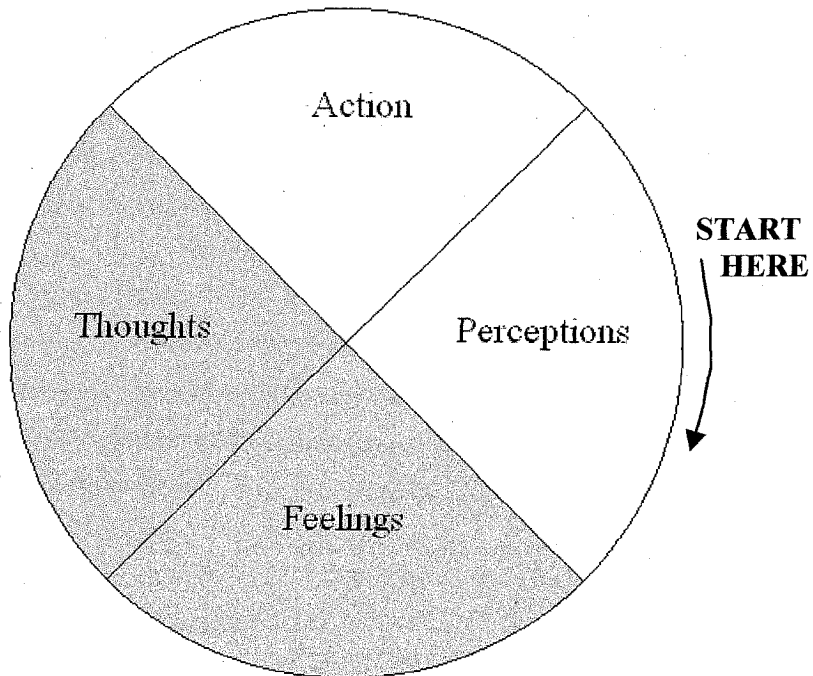


**EVOLVED OVERALL QUESTION: WHAT ARE THE PERCEPTIONS OF HIGH-RISK PREGNANT URBAN ABORIGINAL WOMEN DURING THE TIME OF PREGNANCY?**

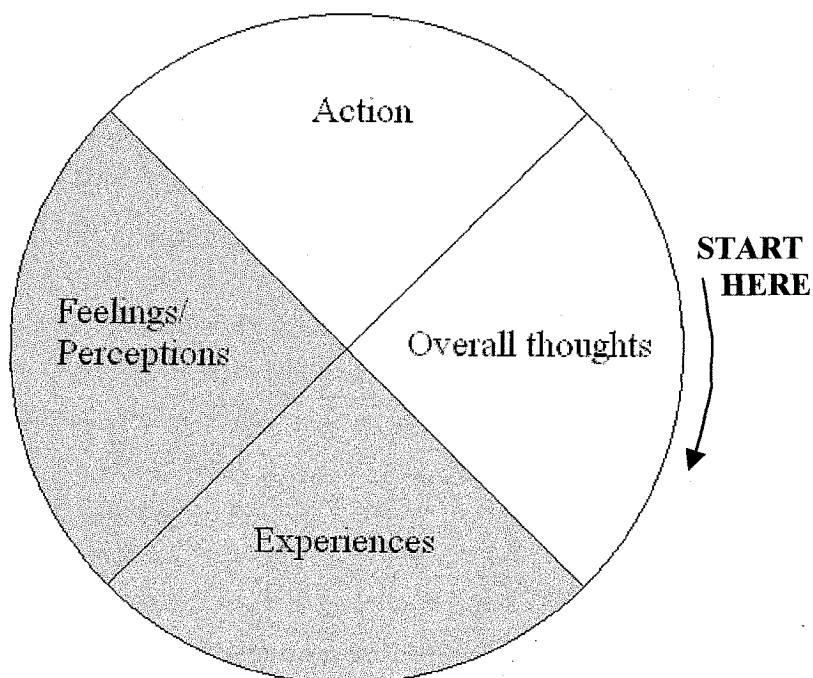
**APPENDIX F**  
**THE AWARENESS WHEEL**

A communication tool

Presented by Dr. John Bird, Aboriginal Psychologist  
Men's Wellness Conference, Saskatoon, 1995

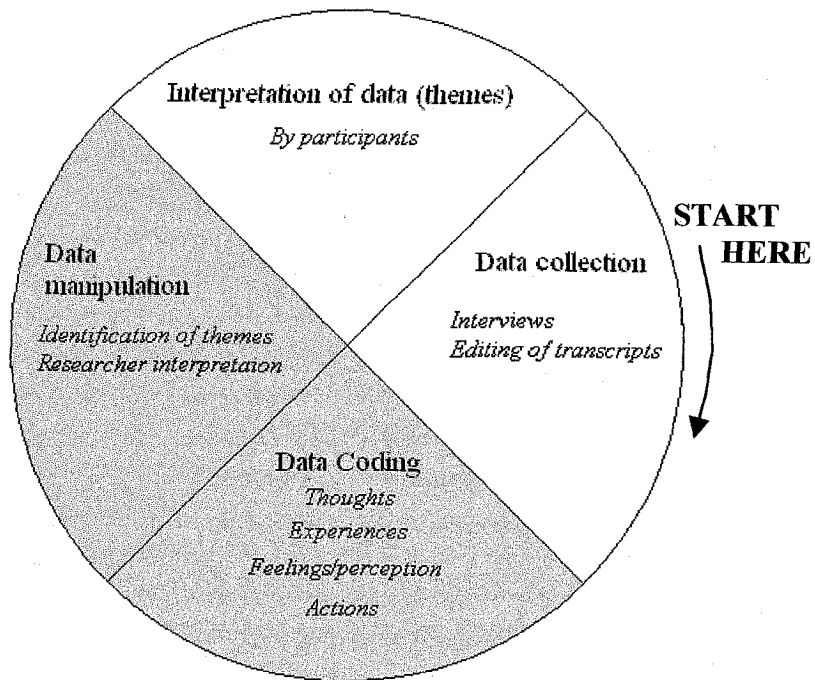


**Revised to:**

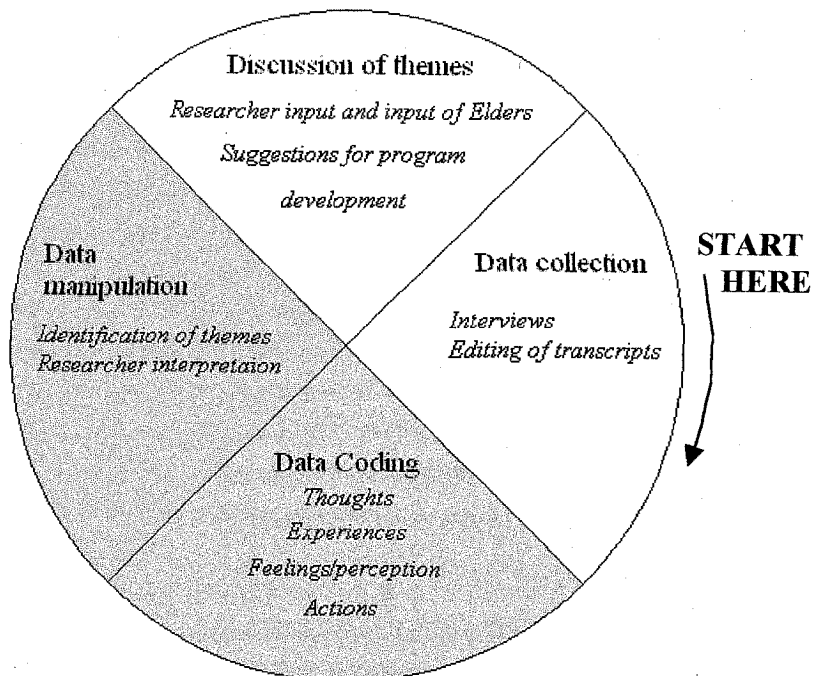


## APPENDIX G

## (ORIGINAL) ILLUSTRATIVE MODEL OF DATA ANALYSIS



## REVISED MODEL OF DATA ANALYSIS

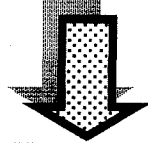


## APPENDIX H

### CODING OF DATA AND DEVELOPMENT OF THEMES

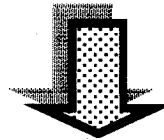
#### DATA SOURCES

- Transcripts
- Picture Probe
- HMHB Profile



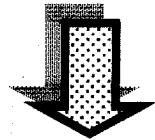
#### COLLATING DATA

Participants code name  
 Transcript number  
 Line numbering  
 Categories (thought, experience, feeling/  
 Perception, action).



#### CODING BLOCK SUB-CODES

- 1.1 Having babies source of happiness for mother.
- 1.2 Having babies source of pride for mother.
- 1.3 Having babies source of love for the mother.
- 2.1 Women want better relationships with their children than what they had.
- 2.2 Women want good relationship with their partners.
- 2.3 Women want a good family life.
- 2.4 Women have limited expectations of father.
- 2.5 Women want to 'be there' for their children.
- 3.1 Women reach out for help and try to help themselves.
- 3.2 Women have ideas for their future as it relates to themselves.



#### DEVELOPMENT OF THEMES

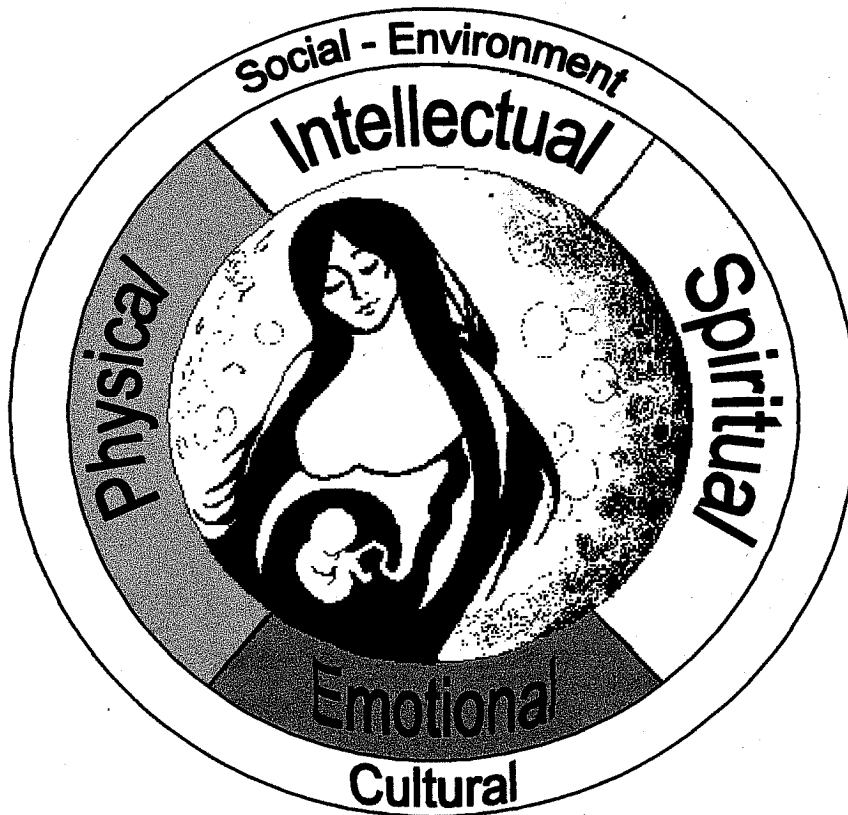
##### HOPES AND DREAMS:

1. A Woman's Need to love and to be loved.
2. To Have a Good Family
3. Personal Ambition and Growth

## APPENDIX I

## PICTURE PROBE

By Sue Wilson, 1998





## APPENDIX J

### PARTICIPANT DESCRIPTION SUMMARY

	Traditional Upbringing	Parental Information	Life Story Information	Education	Income Source	Housing Situation	Significant Other	Children	Father of Children
<b>ANNE</b>	None Raised on and off reserve.	Raised by various family members & Foster parents	Felt neglected during childhood.	No high school diploma.	Social Assist. Supports Boyfriend Financially	Lives in apartment with boyfriend.	Boyfriend unemployed.	Three year old cared for by aunt on reserve	Different father from toddler.
<b>BARB</b>	None Raised on reserve.	Raised by Grandmother for entire upbringing.	Good upbringing. No neglect or abuse.	High School Diploma	Social Assist. Supports Boyfriend Financially	Lives in apartment with boyfriend and his nine year old son.	Boyfriend unemployed	No children	Not applicable
<b>DEB</b>	None Raised on reserve.	Raised by parents- both ETOH abuse.	Neglect during childhood.	Currently in high school.	Social Assist. Supports Boyfriend On occasion.	Lives in apartment with their child and boyfriend visits.	Boyfriend unemployed. Lives mostly with his mother. Deals drugs.	Cares for toddler	Same father for both children.
<b>ELLA</b>	None Raised on reserve until six years of age, then in the city.	Raised by Grandfather until 6 years of age, then alcoholic mother.	Felt neglected during times being cared for by mother.	No high school diploma.	Social Assist.	Lives in apartment with child and boyfriend visits.	Boyfriend lives elsewhere. Employed.	Cares for toddler	Different father from toddler.
<b>FRAN</b>	None Raised on reserve.	Raised by parents. Mother had little time for her.	Neglect and sexual abuse.	No high school diploma	Social Assist. Supports boyfriend	Low rental duplex. Lives with her kids & boyfriend.	Boyfriend Unemployed.	Cares for toddler and four year old.	Different father from her other children.